ALABAMA MEDICAID AGENCY

REQUEST FOR PROPOSALS

(cover sheet)

RFP Number: 2007-TFQ-01	**RFP Title: TFQ Vendor Services**
RFP Due Date and Time: August 2, 2007 by 5:00 p.m., CDT	**Number of Pages: 81**

PROCUREMENT INFORMATION	
Project Director: Kim Davis-Allen	**Issue Date: June 29, 2007**
Phone: (334) 242-5011 **Fax: (334) 353-4818** **E-mail Address: kim.davis-allen@medicaid.alabama.gov** **Website: http://www.medicaid.alabama.gov**	**Issuing Division:** **Together For Quality Unit**

INSTRUCTIONS TO VENDORS	
Return Proposal to: **Kim Davis-Allen** **Director, Medical Services Division** **Alabama Medicaid Agency** **Lurleen B. Wallace Building, Suite 3000** **501 Dexter Avenue** **Montgomery, AL 36104**	**Mark Face of Envelope/Package:** **RFP Number: 2007-TFQ-01** **RFP Due Date: August 2, 2007, 5 p.m., CDT**
	Special Instructions: ***Mandatory Pre-Proposal Conference, July 13, 2007, 9:00 a.m. CDT*** ***Letter of Intent Due July 20, 2007, 5 pm CDT***

VENDOR INFORMATION ***(Vendor must complete the following and return with RFP response)***	
Vendor Name/Address:	**Authorized Vendor Signature:** **(Please print name and sign in ink)**
Vendor Phone Number:	**Vendor FAX Number:**
Vendor Federal I.D. Number:	**Vendor E-mail Address:**
Proposal is original or copy. Indicate: ☐ **Original** ☐ **Copy**	

Section A. RFP Checklist

1. ____ **Read the *entire* document.** Note critical items such as: mandatory requirements; supplies/services required; submittal dates; number of copies required for submittal; contract requirements (e.g., contract performance security, performance and/or reporting requirements, etc.).

2. ____ **Note the project director's name, address, phone number and e-mail address.** This is the only person you are allowed to communicate with regarding the RFP and is an excellent source of information for any questions you may have.

3. ____ **Attend the mandatory pre-proposal conference**. This conference provides an opportunity to ask clarifying questions, obtain a better understanding of the project, or to notify the State of any ambiguities, inconsistencies, or errors in the RFP.

4. ____ **Take advantage of the "question and answer" period.** Submit your questions to the project director by the due date listed in the Schedule of Events and view the answers as posted on the WEB. All addenda issued for an RFP are posted on the State's website and will include all questions asked and answered concerning the RFP.

5. ____ **Follow the format required in the RFP** when preparing your response. Provide point-by-point responses to all sections in a clear and concise manner.

6. ____ **Provide complete answers/descriptions.** Read and answer **all** questions and requirements. Do not assume the State or evaluation committee will know what your company capabilities are or what items/services you can provide, even if you have previously contracted with the State. The proposals are evaluated based solely on the information and materials provided in your response.

7. ____ **Use the forms provided**, e.g., cover page, disclosure form, pricing sheets, equipment requirement listing, certification forms, etc.

8. ____ **Check the State's website for RFP addenda.** It is the Vendor's responsibility to check the State's website at www.medicaid.alabama.gov for any addenda issued for this RFP, no further notification will be provided. Vendors must submit a signed cover sheet for each addendum issued along with your RFP response.

9. ____ **Review and read the RFP document again** to make sure that you have addressed all requirements. Refer to Appendix A for Responsiveness Requirements. Your original response and the requested copies must be identical and be complete. The copies are provided to the evaluation committee members and will be used to score your response.

10. ____ **Submit your response on time.** Note all the dates and times listed in the Schedule of Events and within the document, and be sure to submit all required items on time. Late proposal responses are ***never*** accepted.

11. ____ **Sign and Return the Contract and Attachments** (Appendix H) to expedite the contract approval process. The successful contract will have to be reviewed by the State's Contract Review Committee which has strict deadlines for document submission. Failure to submit the signed contract can delay the project start date but will not affect the deliverable date.

This checklist is provided for assistance only and should not be submitted with Vendor's Response.

Section B. Schedule of Events

The following RFP Schedule of Events represents the State's best estimate of the schedule that shall be followed. Except for the deadlines associated with the vendor question and answer periods and the proposal due date, the other dates provided in the schedule are estimates and may be impacted by the number of proposals received. The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. Notification of any adjustment to the Schedule of Events shall be posted on the RFP website at www.medicaid.alabama.gov.

EVENT	DATE
TFQ RFP Issued	6/29/07
Deadline for Questions before Vendor Conference	7/09/07
Answers to Questions Posted Daily by 5 pm CDT	7/09/07- 7/12/07
Mandatory Vendor Conference; 9 am CDT	7/13/07
Final Posting of Questions and Answers	7/17/07
*Letter of Intent to Submit Proposal Due by 5 pm CDT	7/20/07
Proposals Due by 5 pm CDT	8/02/07
Evaluation Period	8/04/07 – 8/13/07
Contract Award Preliminary Notification	8/14/07
**Legislative Contract Review Committee Meeting	9/06/07
Official Contract Award (Approximate)	9/13/07

**Submission of a letter of intent does not legally bind a vendor to submit a proposal, but is required if a proposal is submitted.*

** *By State law, all contracts must be reviewed by the Legislative Oversight Committee. The Committee meets monthly and can, at its discretion, hold a contract for up to 45 days.*

TABLE OF CONTENTS

I. Background

A. Systems Transformation Grant Initiative

The Alabama Medicaid Agency (hereinafter sometimes referred to as ALMA, Medicaid, the Agency or the State), as part of its transformation grant activities, is seeking to award a contract to a Contractor (hereinafter sometimes referred to as Vendor) for the development of an integrated open systems health information system that links ALMA, state health and human service (HHS) agencies, providers and private payors and establishes a comprehensive, quality improvement model for the Alabama Medicaid Program. The State also seeks to develop a claims based electronic clinical support tool (ECST) accessible through the web that will enhance provider care management. A copy of the ALMA grant proposal, called ***Together for Quality,*** is available at www.medicaid.alabama.gov.

The success of the planning, design, development, implementation, and adoption of ***Together for Quality*** depend on several prevailing principals.

1. The TFQ governance structure includes a comprehensive Stakeholder Council, five (5) functional working committees (Clinical, Technical, Finance, Policy, and Legal), and steering committee. These groups serve as a fundamental component in reviewing design, implementation, and adoption strategies.

2. TFQ is a quality improvement program that will be designed for and by representatives of Medicaid's Patient 1st Program (primary care case management / medical home model).

3. Tools and quality initiatives designed and implemented through the TFQ project will provide solutions valuable and hassle neutral for Medicaid's medical home providers.

4. TFQ will build upon existing technology and solutions and will not reconstruct existing data repositories that reside within Alabama. While TFQ will leverage existing data repositories, the project will develop new, user friendly, provider hassle neutral tools to support the common goals of the Medicaid Patient 1st Program that will continue to be governed by Medicaid and its Stakeholder Council.

5. Recommendations for the design and implementation of tools and programs within TFQ will be continue to be made through the TFQ Stakeholder Council and Steering Committee.

One of the goals of ***Together for Quality*** is to develop a system of electronic communication that allows all state health and human services (HHS) agencies to share information about common recipients efficiently and effectively. This system, referred to as the Alabama Health Information System (ALAHIS), will also assist the ALMA and

others to 1) improve the quality of care of patients by providing the tools that support the coordination of services and the communication of the patient health status across the patient's medical home and their specialty care providers, 2) enhance opportunities for continuous healthcare improvement and at the same time reduce wasteful resources due to uncoordinated, duplicative, ineffective and unnecessary services, and 3) promote the adoption of evidence-based medical care and care-coordination programs through increasing the awareness and participation to available disease management protocols aimed at improving health outcomes and preventing further disease complications among patients.

In Alabama, ALMA and other HHS agencies are separate agencies that share data with the same limited approach in which healthcare is often delivered (i.e. fragmented, duplicated, and with insufficient information at the point of provider/patient decision). Shared patient/client information is not well-integrated electronically among ALMA and Alabama's other HHS agencies. Typically, HHS agencies create programs and systems to serve their own specific organizational or accountability needs that are oftentimes duplicated among the agencies. This silo approach contributes to substantially higher costs and eligibility error rates, inappropriate billing, duplicated services, missed opportunities for efficiencies, and less than optimal service delivery approaches and outcomes.

Also in Alabama, care is delivered by a variety of providers working in a broad spectrum of inpatient and ambulatory settings, utilizing various levels of technology and in some cases no clearly defined standards of treatment. Medicaid providers have difficulty obtaining complete health care information to provide effective and beneficial treatment to their patients.

In order to address these inefficiencies, inadequacies and inconsistencies in care caused by information fragmentation, ALMA via ***Together for Quality*** is seeking proposals for the development of an open systems based health information exchange (HIE) infrastructure that will 1) allow all HHS agencies to share information about common recipients efficiently and effectively, and 2) empower providers with an ECST with clinically-relevant information and data necessary for patient management and monitoring as well as coordination of care for their patients.

The ***Together for Quality*** goals are twofold:

1. Connectivity and interoperability among Alabama's HHS agencies to establish efficient, electronic information sharing that improves health and controls cost.

2. Development of a web-based ECST which provides real-time, expeditious access to individual health information from disparate systems, including electronic medical records (EMR), claims data, immunization registries, prescription data, and laboratory results into a modified electronic health record (EHR) for Medicaid providers to use to improve patient care. Additionally, in partnership with Federally Qualified Health Centers, Rural

Health Clinics, and hospital emergency rooms. Alabama hopes to develop a process for creating health records for uninsured individuals.

The ***Together for Quality*** partners are committed to the vision of creating and implementing a system where shared clinical data will result in improved patient care and clinical outcomes in a safe and secure environment where health care costs are controlled. ALMA intends to implement an interoperable system based on national standards capable of interfacing with multiple applications and supporting various end user devices. This RFP outlines the minimal requirements for such a system. Vendors must submit proposals which outline how the minimal requirements will be met and are encouraged to share innovative approaches exceeding minimal requirements.

The State of Alabama has a unified state-wide infrastructure. At its core is a secure high speed campus network that connects all state agencies. Authentication for state agencies within the State forest is carried out via a robust Active Directory (AD) forest and the Alabama Consolidated Email (ACE) system provides a unified Exchange messaging system to all state agencies. SQL Server is the state supported database software and BizTalk™ is the state's chosen middleware solution to provide the efficient sharing of electronic information between agencies. The vendor's proposed solution must utilize the state's infrastructure for connectivity and interoperability among Alabama's HHS agencies**.**

B. General Background Information

ALMA is responsible for the administration of the Alabama Medicaid Program under a federally approved State Plan for Medical Assistance. Through teamwork, the Agency strives to enhance and operate a cost efficient system of payment for health care services to low income individuals through a partnership with health care providers and other health care insurers, both public and private.

Medicaid's central office is located at 501 Dexter Avenue in Montgomery, Alabama. Central office personnel are responsible for data processing, program management, financial management, program integrity, general support services, professional services, and recipient eligibility services.

For certain recipient categories, eligibility determination is made by Agency personnel located in ten (10) district offices throughout the state and by one hundred eighty (180) out-stationed workers in designated hospitals, health departments and clinics. Medicaid eligibility is also determined through established policies by the Alabama Department of Human Resources and the Social Security Administration. In FY 2005, more than 960,000 Alabama citizens were eligible for Medicaid benefits through a variety of programs.

Services covered by Medicaid include, but are not limited to, the following:

- Physician Services
- Inpatient and Outpatient Hospital Services
- Rural Health Clinic Services

- Laboratory and X-ray Services
- Nursing Home Services
- Early and Periodic Screening, Diagnosis and Treatment
- Dental for children ages zero (0) to twenty (20)
- Home Health Care Services and Durable Medical Equipment
- Family Planning Services
- Nurse-Midwife Services
- Federally Qualified Health Center Services
- Hospice Services
- Prescription Drugs
- Optometric Services
- Transportation Services
- Hearing Aids
- Intermediate Care Facilities for the Mentally Retarded and Mental Disease Services
- Prosthetic Devices
- Outpatient Surgical Services
- Renal Dialysis Services
- Home and Community Based Waiver Services
- Prenatal Clinic Services
- Mental Health Services

Additional program information can be found at www.medicaid.alabama.gov.

Partnership Hospital Program (PHP)
The Partnership Hospital Program was implemented in 1996 under the authority of a 1915(b) waiver. In 2002, the waiver was not renewed by the federal government and the program now operates under the authority of the State Plan. It is considered to be a Prepaid Inpatient Health Plan. Through this program the state is divided into eight districts. Medicaid pays each PHP a per member, per month fee for acute inpatient hospital care for most Medicaid eligibles living in the district. Inpatient hospital days are limited to 16 per calendar year for most adult patients. Approximately $35 million is paid each month in capitation payments.

Maternity Care Program
The Maternity Care Program was implemented in 1988 under the authority of a 1915(b) waiver from the federal government and was converted to a State Plan option in 1999. It was transitioned back to a 1915(b) waiver in 2005. Through this program the state is divided into fourteen (14) districts. Each district is responsible for the implementation of a coordinated, comprehensive system of maternity services for prenatal and delivery care. Upon delivery, the Primary Contractor is paid a global fee for all components of care. The fee is established based on a bid price obtained through a competitive procurement process. The annual budget for the Maternity Care Program is approximately $120 million.

Pharmacy Program
Medicaid pays for most medicines legally prescribed by a doctor or authorized health professional when dispensed by a licensed doctor or pharmacist in accordance with

state and federal laws. In FY 2005, Medicaid paid for 11.6 million prescriptions for qualifying Alabama recipients. Medicaid utilizes various programs to insure pharmaceuticals are used appropriately and in a cost efficient manner. These programs include: Maximum Allowable Cost (MAC) Pricing, Preferred Drug List (PDL), monthly brand limit, drug prior authorization (PA), maximum monthly unit edits, therapeutic duplication edits, and prospective and retrospective drug utilization review (DUR) systems.

Patient 1st Program

More than 420,000 Alabamians currently participate in Patient 1st, a primary care case management (PCCM) program operated by Medicaid. The current program was approved by the Centers for Medicare and Medicaid Services (CMS) in August 2004 and includes expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting better care for Medicaid patients.

Long Term Care

Medicaid administers a comprehensive program of long term care services that offers eligible individuals a wide range of care choices as well as increased opportunities to receive services at home or in the community. Long term care services include home health services, durable medical equipment, hospice care, private duty nursing and targeted case management as well as care in nursing and other long term care facilities. Six (6) waiver programs provide alternatives to institutional care. Home and community-based waiver programs (HCBS) are available to eligible Medicaid recipients who are at risk of needing care in a nursing home, hospital or other institution. Individuals shall meet financial, medical and program requirements. Waiver program enrollment is limited by the number of approved slots. These programs include:

a. Elderly & Disabled Waiver
b. HIV/AIDS Waiver
c. Living at Home Waiver
d. Mental Retardation Waiver
e. State of Alabama Independent Living Waiver
f. Technology Assisted Waiver for Adults

More information on long term care services and home and community options may be found at www.medicaid.alabama.gov.

All information contained in the Request for Proposal (RFP) and amendments reflect the best and most accurate information available to Medicaid at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for change of the payments to the Contractor or a basis for legal recovery of damages, actual, consequential or punitive except to the extent that such inaccuracies are the result of intentional misrepresentation by Medicaid.

II. IDENTIFICATION OF PILOT STAKEHOLDERS

Through the leadership of Governor Bob Riley and ALMA, ***Together for Quality*** (TFQ) brings together state agencies, clinics, hospitals, physicians, pharmacies, private insurers and other stakeholders so that mutual interests and needs can be addressed. Realizing that it is impossible to establish a health information exchange between all stakeholders during the TFQ transformation grant timeframe and based upon the TFQ goals, the following stakeholders have been selected to participate in the pilot:

a) **Connectivity and interoperability among Alabama's HHS agencies to establish efficient, electronic information sharing that improves health and controls cost**.

   The Alabama Department of Senior Services (ADSS) has been selected as the pilot HHS agency for establishment of connectivity and interoperability.

b) **Development of a web-based electronic clinical support tool (ECST) which provides real time, expeditious access to individual health information from disparate systems, including electronic medical records (EMR), claims data, immunization registries, prescription data, and laboratory results into a modified electronic health record (EHR) for Medicaid providers to use to improve patient care**.

   As many as 500 Medicaid providers to be determined by ALMA will be included in a pilot to test the ECST. It is the intention of ALMA to obtain a broad representation of Medicaid providers, primarily physicians, federally qualified health centers, rural health clinics and hospital emergency rooms by including providers from urban and rural populations and providers currently utilizing no information technology to practices/clinics utilizing custom and off-the-shelf EMR systems. ***The cost for any equipment or telecommunications needed by pilot providers to establish connectivity with the web-based ECST will be reimbursed outside of vendor's proposal.***

III. TECHNICAL REQUIREMENTS

Each vendor proposal must provide a solution that accomplishes the goals of this RFP to link all identified resources and stakeholders through web based technology and network connectivity to develop and deploy the health information exchange solution in Alabama. The solution presented must be based on open systems technology where proprietary components and solutions are avoided and must address all requirements identified in this RFP.

Each vendor proposal must provide the following:

1. A high-level technical diagram with a description of the proposed solution to demonstrate the interconnectivity of the ALMA HIS components identified in section IV "Integration and Interface Requirements",

2. An overall technical architecture diagram with a description and purpose of each component identified in the diagram including, but not limited to, servers, firewalls, routers, switches and security layer(s), network technologies for land lines, Local Area Networks (LANs), Wide Area Networks, (WAN), fax, wired and wireless transmission media (twisted wire, cable, fiber optic, infrared, light, radio, microwave, satellite, Broadband air cards, WiFi, Blue Tooth) and electronic devices such as Personal Computers (PCs), laptops, tablet PCs, Personal Digital Assistants (PDAs), smartphones, etc…

3. A technical architecture diagram of the HHS agency inoperability solution with a description and purpose of each component identified in the diagram, to include Finance ISD's BizTalk™ middleware solution (identified in this RFP) and security layer(s),

4. A high-level diagram and description of the web-based ECST and EHR solutions to include a description of the open systems and any proprietary software used in the solution in addition to connectivity options for urban and rural end users with limited or no Internet Service Provider (ISP) services,

5. A separate table that lists equipment and detail specifications for each item that must be purchased by the State of Alabama in order to successfully implement the proposed solution. The table format is included in Appendix G. The purpose of each item must be also be provided,

6. A separate table that lists software, detail specifications for each item, and the purpose of each item that must be purchased by the State of Alabama in order to successfully implement the proposed solution. The table

format is included in Appendix G. The purpose of each item must also be provided;

7. A solution via the web-based ECST to use a rules based query engine to query and display results from the various data sources identified throughout this document and governed by end user credentials, rights and privileges, and

8. A solution that provides notification services needed to react to an event such as a change in eligibility data recognized by the data monitoring service. The notification service then notifies all those systems and individuals who have registered to receive such notifications of that change using whatever tools they prefer, such as system-to-system transactions, database updates, emails, instant messaging, fax, or other options. These services can also be associated with other types of notification services such as publish and subscribe, store and forward, hub and spoke, event–based notifications, and message-enablement.

Vendor proposals should also address the following:

1. Describe in detail your solution for collecting data and input for HIS development and maintenance.

2. Describe in detail the end-user tools available in your HIS solution that providers can use to customize the software (e.g., create new alerts, r eminders).

3. Describe in detail your solution process and support activities (release schedule, communication, training, etc).

4. Describe in detail any components of your solution certified through CCHIT (The Certification Commission for Healthcare Information Technology).

5. Describe in detail how your HIS technical architecture enables integration of third party software to include but not be limited to practice management systems, governmental agency systems, private payor systems and Microsoft BizTalk™.

6. Describe in detail any current third party connectivity/integration with your HIS solution (e.g., formulary and prescribing services, practice management systems, decision support providers, laboratory systems, and other functional components outlined in Section VI).

7. Describe any future plans for strategic partnerships that involve your solution.

Note: All hardware and software required for the development and deployment of the State Agency health information exchange solution will be purchased via an Invitation to Bid (ITB) or through state contract and will be licensed and owned by the State of Alabama. Therefore hardware and software costs for this purpose must not be included in the total cost of the proposal. The State shall provide any annual maintenance on software and equipment purchased by the State to satisfy the awarded solution.

Professional services costs associated with setup, configuration, software development, deployment and maintenance of equipment and software must be included in the total cost of the proposal.

IV. INTEGRATION AND INTERFACE REQUIREMENTS

Seamless interoperability of data and speedy access/retrieval of this data by the user are key to the success of the TFQ initiative. Movement of data will require shared standards for claims, demographic, clinical and quality data exchange. While some of these exchange capabilities will be required immediately, others will be demanded as Alabama's healthcare information infrastructure develops. It is anticipated that the clinical data exchange will develop around a master patient index and record locator service. This centralized index will greatly simplify the process of locating and retrieving clinical data about a given patient through a record locator service. In this model, data will be transported over the Internet using standard secure socket layer protocols and will use SOAP/XML envelopes as part of the transport of clinical data wherever possible.

As previously stated, the TFQ goals are twofold:

1. Connectivity and interoperability among Alabama's HHS agencies to establish efficient, electronic information sharing that improves health and controls cost.

2. Development of a web-based ECST which provides real-time, expeditious access to individual health information from disparate systems, including electronic medical records (EMR), claims data, immunization registries, prescription data, and laboratory results into a modified electronic health record (EHR) for Medicaid providers to use to improve patient care. Additionally, in partnership with Federally Qualified Health Centers, Rural Health Clinics, and hospital emergency rooms. Alabama hopes to develop a process for creating health records for uninsured individuals.

The information technology infrastructure and architecture of state government as a whole in Alabama is moving toward common platforms and interfaces. In support of this paradigm shift, the following is an excerpt from a report of recommendations from the Governor's Task Force to Strengthen Alabama's families:

> **Common Client Index**
> The ability to create a common client index (CCI) enables organizations and their partners to create a single trusted view of a customer across disparate information systems and multiple access channels. This is achieved by matching and cleansing data, which has been aggregated from silos of information currently held across the organization or partner agency systems, and presenting this information as a unified view across all access channels. Access to an integrated view of the customer enables organizations to deliver improved and consistent services and ensures customers can be accurately identified and reliably tracked across multiple systems. The CCI provides a single view of a client or family. It will enable a unified view of the client from individual back-end

systems to support improved levels of customer service by the provision of quick access to more accurate and complete information.

The CCI is used in the Connected HHS Framework to create an index, much like an index in a book, that lists all the identifiers used for a person in all the state systems When information is needed in one system about a person from another system, the query first looks in the CCI to get the person's system identity, and uses that identifier to fetch the information desired. A number of indexes will be created for entities other than clients, including indexes for providers, buildings, and other items or organizations that are used by multiple organizations.

In support of goal #1, the Information Services Division (Finance – ISD) is responsible for the infrastructure and architecture for the exchange of electronic information for state agencies (**Policy 500-00: Statewide Information Systems Architecture**). At the core of the unified state-wide infrastructure is a secure high speed campus network that connects all state agencies. Authentication for state agencies within the State forest is carried out via a robust Active Directory (AD) forest and the Alabama Consolidated Email (ACE) system providing a unified Exchange messaging system to all state agencies. SQL Server is the state supported database software and BizTalk™ is the state's chosen middleware solution to provide the efficient sharing of electronic information between agencies. The Vendor must ensure that the proposed solution safeguards access to data and modules. Users who are not authorized to access certain applications and/or data will be prohibited from retrieving, viewing, using, or otherwise acquiring access. Security privileges will be tied to roles and administered by State staff. The Finance ISD Office and Medicaid Information Systems Division will manage access to the system (Internet and Intranet) and will manage network access security. Each vendor proposed solution must utilize the state's infrastructure for connectivity and interoperability among Alabama's HHS agencies**.** Additionally, each vendor proposal must meet all Medicaid and Finance - ISD data processing hardware and software standards and also must comply with the State of Alabama security policies as outlined in Statewide Information Technology Policies Index (http://isd.alabama.gov/policies/policies.aspx).

State infrastructure and architecture

Exchange 2000 (Migrating to Exchange 2007)
Active Directory (Single forest with multiple domains)
SharePoint 2007
BizTalk™ 2007
VMware
SUN\Hitachi SAN
Visual Studios (.Net)
HP Blade servers
250 Meg Internet Connection
CISCO (routers, switches and firewalls)
Model IBM 2066-003 Z Series 800 Processor Mainframe

In support of goal #2, Medicaid desires to implement a hybrid EHR whereby limited data is held in a centralized data repository while most patient data is held by the system in which it is created. Each vendor proposal must provide a detailed description of the technology it intends to use to develop and deploy the EHR solution in Alabama. The system architecture should be service-oriented and able to allow access by health care providers and other state agencies at a minimum to the following data bases which currently exist in Alabama:

- Immunization Data
- Demographic, Claims, and Lab Data
- Online Disaster Network
- Emergency Patient Information
- AIMS
- Pharmacy Prior Authorization
- Health Records for Uninsured Individuals
- EMR systems- Integration (push/pull capability)

These databases are described further in Appendix C. Each vendor proposed solution must be able to exchange information with these systems.

Each vendor proposal must provide a description of the proposed solution's ability to integrate with and interface to the above referenced and other systems. This description must detail:

1. The ability to connect to source systems, to collect data from them, and to allow data consumers to get at the data utilizing various methods. Specifically, clinicians with existing EMR products should have data appear seamlessly in existing primary applications utilizing "push/pull" capabilities.
2. The methodology for establishing a master patient index, including the hit ratio for implemented solutions based on end user requests and successful retrieval of the correct patient information using master patient index methodology.
3. The standard integration approach including the number of existing client installations using this standard.
4. A list of current health information system interfaces along with a description of the points of integration.
5. The ability and/or plans to offer a service-oriented data exchange architecture including the number of existing client installations using these services.

	Integration and Interface Checklist	
Functionality	**Vendor Solution**	**Additional Features**
Master Patient Index		
Record Locator Service		
Integration Engine		
Terminology Management		
Patient Data Hub		
ECST • Immunizations • Claims data • Lab results • Emergency information • AIMS • Pharmacy Prior Authorization • Health Records for Uninsured Individuals		
Infrastructure • Servers • Network • Storage area network		

	Exchange Standards Checklist				
Data Exchange Type	**Proposed Standard**		YES	NO	Comments If No, explain here.
Demographics	Exchange Standard Vocabulary	HL7 version 2.4 or higher			
Medications	Exchange Standard Vocabulary	HL7 version 2.4 or higher NCPDP (retail pharmacy) NDF-RT, RxNorm (inpatient pharmacy) AHFS, NDC, FDB			
Problem/Symptom	Exchange Standard Vocabulary	HL7 version 2.4 or higher ICD9-CM, SNOMED CT			
Major Procedures	Exchange Standard Vocabulary	HL7 version 2.4 or higher CPT-4, HCPCS, SNOMED CT			
Immunizations	Exchange Standard Vocabulary	HL7 version 2.4 or higher CPT-4, SNOMED CT			
Allergies	Exchange Standard Vocabulary	HL7 version 2.4 or higher Free text, SNOMED CT (reaction), Medications (see above), Unique Ingredient Identifier (UNII) for environment/food			
Hospital/ Physician Visits	Exchange Standard Vocabulary	HL7 version 2.4 or higher ICD-9-CM (physician), HL7 version 2.4 (hospital)			

Lab/Micro/Rad Reports	Exchange Standard Vocabulary	HL7 version 2.4 or higher CPT-4, LOINC (lab/micro order names), SNOMED CT (lab/micro results), DICOM (images, faxes)			

The proposed solution must ensure consistent terminologies, data accuracy, and semantic interoperability through compliance with health care transaction standards, standard vocabularies, and code sets. The solution must support reference to standard and local terminologies ensuring consistent use of vocabulary. Examples of terminologies include LOINC, SNOMED, applicable ICD, CPT and messaging standards such as X12 and HL7. Maintenance of any utilized standards must be ensured and solutions must incorporate current terminologies and code sets utilized by the ALMA. Standards based interoperability must ensure that the integration is seamless and modifiable to some degree with the automatic integration of the data flowing through the Patient Data Hub into existing EMR systems. Specific data will be identified e.g. patient entered data and shall allow the provider to determine whether such data is to be accepted into their EMR.

V. HHS AGENCY INTEROPERABILITY

The ALMA has selected the Alabama Department of Senior Services (ADSS) to serve as the pilot health and human service agency to implement and demonstrate the interoperability component of TFQ as it relates to governmental entities. ADSS currently has a client/server application in place called Aging Information Management System (AIMS). AIMS is a comprehensive database application for tracking clients and services for Alabama's Aging Network. The system was designed originally from a need to set up one central area to house client information in order track clients, the services they receive and provide real-time reporting. Prior to the development of this system, information had to be gathered from several different sources and manually entered. The database has real-time data as well as cumulative data (it maintains history files for any services received). It is an established and proven database that has been in existence since the mid-1990s. AIMS serves as a case management, program monitoring, auditing, and billing tool.

At a minimal, the electronic information exchange system must consist of the following components:

1. Access to ADSS AIMS database to utilize information from the Home and Community Based Waiver (HCBS) Service Authorization Form, HCBS Waiver Care Plan, HCBS Waiver Program Assessment Form, Admission and Evaluation Data, and the HCBS Medication List Form for review and feedback by ALMA staff to exchange information on program guidelines and compliance with alert response of modification to designated ALMA and ADSS staff.

2. Ability to identify ADSS service providers listed by name and provider number through AIMS database and be accessible and updatable by both agencies.

3. Provide for information exchange between agencies for approval and re-approvals of Adult Day Health providers' compliance with ALMA Adult Day Health Standards and record the response in the ADSS database and alert designated ADSS staff of update.

4. The ability to access claims data identified by HCBS procedure codes viewable by ALMA and ADSS with the ability to retrieve data by date range up to twelve (12) months.

5. A common HCBS complaint repository that shall have functionality to:
   - Record, track, and report on ALMA and ADSS HCBS complaints to resolution,
   - Restrict accessible to ALMA and ADSS designated personnel,
   - Restrict modification of specified ALMA and ADSS data elements,
   - Log and report access and modifications to data elements,

6. The ability to request Corrective Action Plans (CAP) from ADSS for discrepancies identified during audit and the ability for ADSS to respond to the CAP and ALMA to approve or disapprove the CAP.

7. The ability for an automatic system prompt with a thirty day notification to alert both agencies of audit dates for ADSS to audit Direct Service Providers and ALMA to audit case management activities.

8. The ability for ADSS and ALMA to review data on ALMA specific indicator reports and exchange responses between agencies.

9. The ability to alert ADSS and ALMA of providers enrolled or requesting enrollment that have been identified as noncompliant, fraudulent, criminal, or having had a history of abusive activities with information only modifiable by reporting agency.

10. The ability for ADSS and ALMA to view HCBS client's health information included in the ECST.

VI. ELECTRONIC CLINICAL SUPPORT TOOL (ECST)

Each proposal must include a statement describing the vendor's ECST solution. The Clinical Workgroup of the TFQ Stakeholder Council has identified the elements found in Appendix D as critical to the development of a successful, quality-based health improvement system. Vendor's proposed ECST solution must include the worksheet and questions that follow. Additional features should indicate the Vendor's solution that which exceeds minimum requirements. Appendix E is a "use case" scenario that describes the practical application of the ECST.

Functionality	Definition	Vendor Solution	Additional Features
EHR: Electronic Claims Based Health Record	Patient medical record providing service history. Allow 'opt-out' capability for the exchange of restricted data based on patient request e.g. psychiatric data. All patient data in the EHR should be available for access unless it is specifically restricted.		
Electronic Formulary/Drug File Management and Alternatives	Preferred Drug List (PDL) information (ALMA and BCBS) , maximum units, override and prior authorization requirements, generic and therapeutic alternatives at point of prescribing with incorporated drug monographs and prescribing information		
Electronic Drug Risk Management	Drug interaction alerts, therapeutic duplication alerts, low and high dose alerts, drug-condition alerts		
Electronic Pharmacy Prior Authorization/Override Notification	Provide notification through electronic messaging to prescribing provider of approval or denial. Currently physicians and pharmacists can fill out PA requests online through the HID website. The tool should link to this functionality for online submission of PA requests. For more information visit: www.hidmedicaid.com		

Disease and Care Management	Alerts and flags using evidence-based guidelines focusing on chronic disease as well as on prevention shall be incorporated and at a minimum must include ALMA specific QI measures for diabetes and asthma (Appendix F), EPSDT screening guidelines, US Preventive Services Task Force Guidelines USPSTF), Depression screening guidelines (AAFP "Point of Care Guide", PHQ-9). Must be modifiable to allow the addition of new alerts/flags for additional QI measures or changes to measures. Patient risk scoring and predictive modeling tool for utilization by ALMA in risk stratification for care management. Methodology used for risk scoring and predictive modeling must be described in detail.		
Provider Profiler and Peer to Peer Clinical Support	Ability to look at providers within peer groups and based on established measures.		
EPI: Emergency Patient Information	Important patient information regarding allergies, medical conditions, drug intolerances, etc. entered by patient and provider with the source of the information identifiable.		
Laboratory Results	Lab results reporting with normal reference ranges		
Immunization Record	Creation of immunization record from claims data and ImmPRINT registry		
eRx: Electronic Prescribing	Facilitate submission of electronic prescriptions, new and refills and submission to the pharmacy in multiple formats e.g. fax, printable for signature, etc. following standards approved by the Alabama State Board of		

	Pharmacy.		
CDS: Clinical Decision Support	Offer prompts to support the adherence to care plans, guidelines, and protocols and also based on patient specific data at the point of capture.		
CDE: Clinical Data Exchange	Allow submission and receipt of patient information including procedure results from disparate data sources		
Referral Management	Allow the origination, documentation and tracking of referrals between care providers including emergency room, specialty referrals, etc.		

VII. PRIVACY AND SECURITY

Vendor must complete the chart below to describe how the proposed solution complies with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule requirements (45 C.F.R. Parts 160, 162 and 164). The chart is based on Appendix A to Subpart C of Part 164. The vendor should refer to the HIPAA Security Rule for additional detail regarding specific items.

The vendor shall also sign the Business Associate Agreement found as part of the contract in Appendix H.

Standard and Section	Implementation Specification	Vendor Response
Administrative Safeguards		
Security Management Process (164.308(a)(1))	• Risk Analysis • Risk Management • Sanction Policy • Information System Activity Review	
Assigned Security Responsibility (164.308(a)(2))		
Workforce Security (164.308(a)(3))	•Authorization and/or Supervision • Workforce Clearance Procedure • Termination Procedures	
Information Access Management (164.308(a)(4))	• Isolating Health Care Clearinghouse Function • Access Authorization • Access Establishment and Modification	
Security Awareness and Training (164.308(a)(5))	• Security Reminders • Protection from Malicious Software • Log-in Monitoring • Password Management	
Security Incident Procedures (164.308(a)(6))	• Response and Reporting	

Contingency Plan (164.308(a)(7))	• Data Backup Plan • Disaster Recovery Plan • Emergency Mode Operation Plan • Testing and Revision Procedure • Applications and Data Criticality Analysis	
Evaluation (164.308(a)(8))		
Business Associate Contracts and Other Arrangement (164.308(b)(1))	• Written Contract or Other Arrangement for subcontractors and agents	
Physical Safeguards		
Facility Access Controls (164.310(a)(1))	• Contingency Operations • Facility Security Plan • Access Control and Validation Procedures • Maintenance Records	
Workstation Use (164.310(b))		
Workstation Security (164.310(c))		
Device and Media Controls (164.310(d)(1))	• Disposal • Media Re-use • Accountability • Data Backup and Storage	
Technical Safeguards		
Access Control (164.312(a)(1))	• Unique User Identification • Emergency Access Procedure • Automatic Logoff • Encryption and Decryption	
Audit Controls (164.312(b))		

Integrity (164.312(c)(1))	• Mechanism to Authenticate Electronic Protected Health Information	
Person or Entity Authentication (164.312(d))		
Transmission Security (164.312(e)(1))	• Integrity Controls • Encryption	

VIII. DOCUMENTATION, TRAINING, AND PILOT

Vendor must provide a detailed description of how the following activities will be conducted. Based on the system design, the Vendor will be required to develop system documentation, training materials for state staff and end-users, pilot the product with end-users and implement the HHS interoperability component.

A. System Documentation

This task will focus on developing system documentation, developing operating procedures, and planning and scheduling stakeholder training. To provide adequate technical documentation and training, the following activities will be required:

- Create complete system documentation, including all hardware, software, database, and infrastructural components and impacts;
- Develop operating procedures;
- Provide system-specific training to staff.

B. Training

This task will focus on developing detailed plans, documentation, procedures, and presentation materials for conducting training on the system. Specifically, the following activities will be completed:

- Define training goals and requirements based on the various end users of the project;
- Define training timelines;
- Create hands-on training materials;
- Create self-directed, computer-based training curriculum/modules which will be available via internet;
- Schedule training, including scheduling of venues;
- Conduct training.

Training materials must be developed with the end user in mind and must be easily understood by both trainers and trainees.

C. User Manual and Online Help

The Vendor will be responsible for a user manual and developing online help features.

- Create/modify a user manual designed to guide end-users step-by-step. The manual must also include navigation instructions, menu selections, error messages, and detailed instructions on how to perform system tasks;
- Create/modify online help.

As with training materials and curriculum, user manuals and desktop help features must be comprehensive and simple to understand.

D. Establish Help Desk

Vendor will be responsible for providing a toll-free help desk and end user support service beginning with the initiation of the Pilot Test through the end of the transition period. The responsibility for the operation of the help desk remains with the Vendor until formal handover at the conclusion of the project. The help desk shall be available for Medicaid, the HIS end-users as well as the designated HHS Agency. Core hours for the help desk will be 7:00 am to 7:00 pm CDT/CST. The following activities will be required:

- Define and document help desk processes and procedures;
- Staff the help desk to meet the support needs of users during pilot and transition;
- Operate and manage help desk operations during pilot and transition;
- Establish acceptable response time to problems reported.
- Weekly reporting of response times, problems encountered and solutions.

The help desk will be responsible for documenting user problems, providing assistance where possible, and referring outstanding problems to the infrastructure support team, the application development team, or other resources required to resolve the user's problem. The help desk will be responsible for monitoring the resolution of problems and escalating problems that are not being addressed in a timely manner. The help desk will contact the reporting user before closing any problem report.

E. Pilot Test of ECST

This task will focus on coordinating, planning and implementing the pilot test plan of the HIS including the ECST. This process will involve the following subtasks:

- In collaboration with the Agency, further define pilot end users including electronic capability;
- Pilot training including adoption levels as specified by the Agency;
- Implement pilot information and access management as set out in Section VII;
- Execution of "pilot agreements" as designed by the Agency;
- In collaboration with the Agency, define performance and problem resolution guidelines (based on problem severity) to be used during pilot testing;
- Monitor performance and identify problems;
- Evaluate system reliability and performance;
- Modify the system to address problems discovered during the pilot;
- Acceptance of product by end-users.

The Agency will provide the vendor an initial listing of pilot sites as well as their existing capability and the end user goals under this project. For example, if a pilot site currently only has fax capability, the goal may be to move them into a tablet based environment. Managing issues identified during the pilot will be important and a process should be established during this subtask. Vendor is responsible for reaching the adoption level within the pilot test as specified by the Agency.

Problems encountered during the pilot test must be identified and resolved within predefined guidelines.

F. Pilot Test of HHS Interoperability

This task will focus on coordinating, planning and implementing the pilot test plan of the HHS Interoperability component. This process will involve the following subtasks:

- Pilot training including adoption levels as specified by the State;
- Implement pilot information and access management as set out in Section VII.

G. Transition Preparation

To coordinate and prepare for role transitions from Vendor to State staff, several important activities must occur. This process will involve the following subtasks:

- Knowledge transfer from Vendor to Medicaid staff, including scheduling training;
- Preparation of a transition plan detailing the roles and responsibilities for both State and Vendor staff.

IX. IMPLEMENTATION SCHEDULE/DELIVERABLES

A. Schedule of Deliverables

The following Schedule of Deliverables represents the State's anticipated completion of activities through the course of the Project. Vendor's response should acknowledge understanding of the dates and the Project Plan should provide a complete listing of tasks necessary to complete each deliverable. Failure to meet deliverable dates shall result in the imposition of liquidated damages as described in Section XV.GG. Tasks associated with each deliverable are further described in the sections below.

Vendor is required to submit deliverables for approval five (5) business days prior to due date.

Vendor shall invoice the State based on key deliverables as delineated on the Pricing Sheet in Appendix G. Contractor shall submit to Medicaid a detailed invoice for compensation for the deliverable and/or work performed. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

EVENT	DATE
Vendor Meeting with State Staff/Stakeholders (B)	9/19/07
Submission of Final Project Plan (C)	9/21/07
ALAHIS Operating Environment Development (D)	10/05/07
HHS Interoperability Resolution (E)	10/12/07
Data Integration Solutions (F)	11/06/07
Development of Clinical Tool (ECST) (G)	12/03/07
Initial Version of HIS, including ECST (H)	12/10/07
Unit and Integration Testing (I)	completed by 2/04/07
Submission of Training Materials (J)	1/07/07
End User Training (K)	2/01/08-2/29/08
Implementation of Pilot Test (L)	3/01/08
Interface with HHS Agency (M)	5/01/08
Ongoing Support/Maintenance (N)	3/08 – 9/08

B. Vendor Meeting

The purpose of this meeting will be to ensure a clear and concise understanding of the project scope and timeframes. It is anticipated that the Vendor will make a presentation to the Stakeholders Council regarding the Vendor and its proposed solution.

C. Submission of Final Project Plan

The Project Work Plan should describe in detail how the project will be managed to successful completion. The plan should detail project organization, staff roles and responsibilities, project objectives, and stakeholder involvement.

- Project Work Plan
- Project Schedule
- Project Staffing Plan Project
- Risk Management Plan
- Workspace and Facilities Plan
- Communications Plan
- Knowledge Transfer Strategy and Plan

D. ALAHIS Operating Environment Databases

Vendor shall have all the specifications necessary to build the interfaces between the existing databases and patient data hub.

E. HHS Interoperability Resolution

Vendor shall have all the specifications and data element defined to establish the interface.

F. ALAHIS Data Integration Solutions

- Immunization Data
- Demographic, Claims, and Lab Data
- Online Disaster Network
- Emergency Patient Information
- AIMS
- Pharmacy Prior Authorization
- Health Records for Uninsured Individuals
- EMR systems- Integration (push/pull capability) at a minimum with the following

EHS	Encite/Medisys
Medformatix	CPSI
MdSoft	GE
SOAPWare (Soap Notes)	DocWorks®
MiSys	

G. Development of Clinical Tool

Vendor shall present a visual representation of how the ECST will appear.

- Electronic Claims Based Health Record
- Electronic Formulary Management and Alternatives
- Electronic Drug Risk Management
- Electronic Pharmacy Prior Authorization
- Disease and Care Management
- Provider Profiling
- EPI: Emergency Patient Information
- Laboratory Results
- Immunization Record
- eRx: Electronic Prescribing
- CDS: Clinical Decision Support
- CDE: Clinical Data Exchange
- Referral Management

H. Initial Version of HIS, including ECST and HHS

- Review and Validate HIS Web Portal User Interface (UI)
- Review and Validate HIS Administration UIs
- Review and Validate HIS User Access Authorization UIs
- Review and Validate ECST UIs
- Review and Validate HHS UIs
- Review and Validate Query UIs
- Approve or Reject Version of HIS UIs (Rejected Version Recycled to G for Redevelopment)

I. Unit and Integration Testing

- Test HIS Web Portal UIs
- Test HIS Administration UIs
- Test HIS User Access Authorization UIs
- Test HIS ECST UIs
- Test HIS Connectivity to Data Resources
- Test HIS HHS Resource Connectivity to Data Resources
- Test Functionality of ECST Required Components
- Test HHS Functionality of Required Components
- Test and Validate Integration of ECST Components
- Test and Validate Seamless Integration of EHR to EMRs
- Test and Validate Seamless Integrations of EMR to EHRs

- Test and Validate Integration of HHS Component Test and Validate Response Time from Divers Electronic and Transmission Media
- Approve or Reject Version of HIS ECST and HHS Components (Rejected Components Recycled to G for Redevelopment)
- Approve or Reject Testing and Integration of ECST and HHS Components (Rejected Components Recycled to G for Redevelopment)

J. Submission of Training Materials/Documentation

- Finalized Training Schedule/Plan
- Hardware, software, database and infrastructure systems documentation
- Operational Help Desk
- Help Desk Facilities
- Help Desk/Problem Management Software or System
- Help Desk Process and Procedure Manuals

K. End User Training

L. Implementation of Pilot Test Plan

- Assessment of capabilities
- Adoption Levels
- Training
- Pilot Agreements, including security levels
- Problem Resolution
- Coordination of pilot agreements
- Conduct pilot-user training
- Provide pilot support
- Monitor performance and identify problems
- Evaluate system reliability and performance
- Modify the system to address problems discovered during the pilot
- Adoption level as specified by the State

M. Interface with HHS Agency

N. Monthly Ongoing Support/Maintenance

- Toll-free Help Desk
- Ongoing Training
- Ongoing Problem Resolution
- System Warranty and Maintenance

X. PROJECT MANAGEMENT

This project will require the coordination of skilled information technology professionals and effective communications both within the organization and to external stakeholders. Ongoing project management activities focus on ensuring that project resources are used efficiently and that the project outcome delivers the desired product.

A. Project Manager

Vendor shall propose a Project Manager (PM) with a minimum of an undergraduate degree and minimum of two (2) years experience in project management, who shall have day to day responsibility for supervising the performance and obligations under this Contract as well as receive policy direction from the Medicaid Project Director. The PM shall demonstrate overall understanding of electronic health information exchange, specific technical, training and marketing, customer service and quality improvement requirements requested in order to successfully fulfill the obligations of this Contract. In the event the PM does not meet the requirements of Medicaid before or after implementation, Vendor shall recommend a candidate to Medicaid who is capable of performing contract obligations. Vendor shall not change its PM without prior written approval from Medicaid, and such approval shall not be unreasonably delayed or withheld. Vendor shall make a good faith effort to use the PM for not less than twelve (12) months to insure successful contract performance. Vendor shall furnish with its response to the RFP a resume for the proposed PM which shall include the individual's name, current address, current title and position, experience with Vendor, experience with electronic health information exchange, experience with provider relations, relevant education and training and management experience. Vendor shall provide a minimum of two (2) work references for the PM.

The PM shall serve as liaison between Medicaid and Vendor and shall be available and responsible for consultation and assistance with issues arising out of the scope of the Contract. PM shall attend, upon request, Medicaid meetings (telephone or face-to-face), meetings and hearings of Legislative Committees and interested governmental bodies, agencies, and officers. PM shall provide timely and informed responses when operational and administrative issues arise in relations to obligations under this contract. Whenever the PM is not available, Vendor shall provide a designated alternate fully capable of meeting the requirements of this RFP.

B. Project Initiation

These are activities that must be completed to ensure that the project starts on a firm foundation and that the stakeholders are actively involved in decision making and direction setting. Vendor's response should describe the following activities based on the implementation schedule.

- Creating a project work plan and project schedule to include a detailed project schedule indicating the various project tasks, the tasks necessary to meet deliverable dates, their duration, estimated start and completion dates, actual

start and completion dates, critical paths, resources, dependencies, completion percentages, and milestones;

- Creating a project staffing plan, including staffing levels and location of staff for duration of project; an overview of the various positions, skill sets, experience requirements, and percentage of time spent on-site versus off-site;
- Creating a communications plan detailing the Vendor's plan for keeping all project stakeholders informed about project progress and identifying the goals/objectives of project communication and identifying the target audience; minimum requirements of a weekly written status report with a bi-weekly face-to-face meeting with additional meetings scheduled as necessary;
- Creating a project risk management plan, assessing project risks and mitigation strategies from the Vendor's perspective;
- Establishing appropriate workspace and facilities; (NOTE: Medicaid can make available a work station for the Project Manager if requested)
- Creating knowledge Transfer Strategy and Plan detailing a plan for affecting a thorough knowledge transfer from Vendor staff to State staff.

C. Conduct Ongoing Project Management

Managing the activities required will require extensive project management, coordination, and controls. Specific Vendor-conducted activities throughout the duration of the project are:

- Update the project work plan;
- Conduct project team meetings;
- Monitor progress toward the development and implementation plan and key milestones;
- Manage open issues;
- Coordinate project team activities;
- Brief stakeholders on project progress (jointly with State project leaders).

D. Maintain Project Communications

The Vendor must develop a plan for sharing information regarding progress and decisions that have been made regarding functionality. This activity will be necessary to ensure that all stakeholders are kept well informed of project status and any issues that require attention. Specific Vendor-conducted activities related to project communications include:

- Developing a communication strategy and plan with a minimum weekly status report and bi-weekly meetings with State staff;
- Creating periodic project status publications;
- Conducting stakeholder briefings.

XI. PRICING

Vendors must use the Price Schedules in Appendix G to submit proposed costs. A statement must be included on each page of the cost that verifies that the prices quoted shall be effective through the end of the contract period. The State shall not be responsible for any expenses of the Vendor. As such, the Vendor must include all expenses, including travel and lodging, when preparing their Cost Proposal.

Note: All proposals must be on a fixed cost basis for specific deliverables with an overall project cost. The overall project cost will be evaluated. No time-and-materials contracts will be considered.

PRICING SCHEDULE 1: FIRM AND FIXED PROJECT COST

The Pricing Schedule Part I must be completed in full and must include both the Total Fixed Project Cost and the project costs allocated to each deliverable. Vendor should also specify each deliverable's percent of total implementation cost. Vendor must include all expenses, including travel and lodging, when preparing their Cost Proposal.

PRICING SCHEDULE 2: HARDWARE AND SOFTWARE

Vendor is required to list all software and hardware that must be purchased by the State of Alabama to successfully implement the proposed solution. Vendor is NOT to list costs in their proposal. This list must include a complete description of the hardware or software, whether it is proprietary, and its purpose.

Note: Per State of Alabama law, the State must purchase any required hardware and software independently of the Vendor's fixed cost proposal process. Thus, the State will independently verify costs and may use the expected cost as part of the evaluation process.

PRICING SCHEDULE 3: HOURLY RATES

The project director during the course of the contract may identify additional work that was not included in the original scope of work but of importance to the progression of the project. Vendors must provide hourly rates for workers to apply for the contract period. These rates should be classified by position.

XII. CORPORATE BACKGROUND AND REFERENCES

Vendors must meet the following minimum qualifications for consideration:

- A minimum of three (3) years experience in Health Information Exchange Systems design and implementation;
- A minimum of one implementation of a health information system integrating information from three or more databases or repositories utilized at multiple sites;
- A minimum of one implementation of an electronic clinical support tool/system ECST utilized at multiple sites.

Each vendor proposal must provide a statement of the vendor's background including years in business, staffing, financial status, and a profile of current customers. Vendor must also provide information on the contracts that meet the minimum qualifications including an overview of the system(s) and contact information. In addition to this statement, the company's most recent balance sheet must be included along with the completed worksheet below.

A. Company Information

Company Name			
Address			
Telephone			
Web Address			
# of years in healthcare business			
# of years in Health Information Exchange business			
# of total Health Information Exchange employees	Within AL:		Outside of AL:
# of Health Information Exchange installations over last three years	2004:	2005:	2006 to present:
# of Health Information Exchange users per installation over last three years	2004:	2005:	2006 to present:
Average use per month per user	2004:	2005:	2006 to present:
# of ECST installations over last three years	2004:	2005:	2006 to present:
# of ECST users per installation over the last three years	2004:	2005:	2006 to present:
Average use per month per user	2004:	2005:	2006 to present:
Company Contacts	**Name**	**Phone**	**Email**
Business Contact:			
Technical Contact:			

B. Financial Information

Public: yes / no	Symbol:
Private: yes / no	Investors:
Total Annual Revenue:	
Cash:	
Net Income:	
Net Margin %:	
Total Assets:	
Total Liabilities:	

C. Subcontractor(s)

For each proposed subcontracting firm, the Vendor shall provide the following information (referencing the subsections in sequence):

- Subcontracting firm name;
- Complete address of the subcontractor;
- Project tasks to be conducted by the subcontractor;
- Percentage of total project and task-specific work the subcontractor will be providing;
- A written statement, signed by each proposed subcontractor, that clearly verifies that the subcontractor is committed to render the services required by the contract.

D. Client References

Vendor shall provide a minimum of three (3) references for projects of similar size and scope for which the Vendor served as the prime contractor or system developer and implementer within the last three (3) years. These references may be contacted to verify Vendor's ability to perform the contract. The State reserves the right to use any information or additional references deemed necessary to establish the ability of the Vendor to perform the conditions of the contract. Negative references may be grounds for proposal disqualification. If not provided as a direct reference, the State may contact the implemented systems described to meet minimal requirements.

For each reference, the Vendor shall provide (referencing the subsections in sequence):

- The company name of the reference;
- The location where the services were provided (city, state);
- Primary and secondary contact name, title, telephone number, and e-mail address of the client reference;
- A complete description of the project;
- Description of the Vendor's role in the project;
- Beginning and end dates of the project;
- Maximum number of Vendor staff assigned to project at one time.

XIII. SUBMISSION REQUIREMENTS

A. Authority

This RFP is issued under the authority of Section 41-16-72 of the Alabama Code and 45 CFR 74.40 through 74.48. The RFP process is a procurement option allowing the award to be based on stated evaluation criteria. The RFP states the relative importance of all evaluation criteria. No other evaluation criteria, other than as outlined in the RFP, will be used.

In accordance with 45 CFR 74.43, the State encourages free and open competition among Vendors. Whenever possible, the State will design specifications, proposal requests, and conditions to accomplish this objective, consistent with the necessity to satisfy the State's need to procure technically sound, cost-effective services and supplies.

B. Single Point of Contact

From the date this RFP is issued until a Vendor is selected and the selection is announced by the Project Director, all communication must be directed to the Project Director in charge of this solicitation. **Vendors must not communicate with any State staff or officials regarding this procurement with the exception of the Project Director.** Any unauthorized contact may disqualify the Vendor from further consideration. Contact information for the single point of contact is as follows:

Project Director:	**Kim Davis-Allen, Director**
	TFQ/Medical Services Division
Address:	**Alabama Medicaid Agency**
	Lurleen B. Wallace Bldg., Suite 3000
	501 Dexter Avenue
	Montgomery, Alabama 36130-5624
Telephone Number:	**(334) 242-5011**
Fax Number:	**(334) 353-4818**
E-Mail Address:	**kim.davis-allen@medicaid.alabama.gov**

C. RFP Documentation

All documents and updates to the RFP including, but not limited to, the actual RFP, questions and answers, addenda, etc, will be posted to the Agency's website at www.medicaid.alabama.gov.

D. Questions Regarding the RFP

Vendors with questions requiring clarification or interpretation of any section within this RFP must submit questions and receive formal, written replies from the State. Questions to be answered at or before the Vendor Conference must be submitted by the date listed on the Schedule of Events. Each question must by submitted to the

Project Director via email and provide clear reference to the section, page, and item in question. Questions and answers will be posted on the website daily as shown on the Schedule of Events.

E. Vendor Conference

A mandatory Vendor Conference will be conducted at the ***Department of Finance Purchasing Division Auditorium***, ***RSA Union Building, 100 N. Union Street, Suite 192, Montgomery, AL 36130-2401,*** as listed on the Schedule of Events. Vendors may use this opportunity to ask clarifying questions to obtain a better understanding of the project or to notify the State of any ambiguity, inconsistency, or error that they may discover upon examination of this RFP. At this conference, the State will, to the extent feasible, provide oral answers to Vendor questions. Oral responses provided to Vendor questions are informational only and in no way bind the State. Written answers will be posted as noted in the Schedule of Events and constitute the official, binding State responses to all Vendor questions.

F. Letter of Intent to Submit a Proposal

Vendor is required to submit a letter of intent to submit a proposal to the Project Director The letter can be mailed, emailed or faxed. It is the responsibility of the Vendor to ensure receipt of letter by the date specified in the Schedule of Events. Submission of a letter of intent does not legally bind a vendor to submit a proposal, but is required if a proposal is submitted.

G. Acceptance of Standard Terms and Conditions

Vendor should submit a statement stating that the Vendor has an understanding of and will comply with the terms and conditions as set out in this RFP. Additions or exceptions to the standard terms and conditions are not allowed.

H. Adherence to Specifications and Requirements

Vendor should submit a statement stating that the Vendor has an understanding of and will comply with the specifications and requirements described in this RFP.

I. Mandatory Requirements

All requirements set forth in this procurement are considered mandatory. To be eligible for consideration, a Vendor's proposal must meet all requirements in this RFP. The State will determine whether a Vendor's RFP response complies with the requirements. RFP responses that do not meet all requirements listed in this RFP may be subject to point reductions during the evaluation process or may be deemed non-responsive.

J. Order of Precedence

In the event of inconsistencies or contradictions between language contained in the RFP and a Vendor's response, the language contained in the RFP will prevail. Should the State issue addenda to the original RFP, then said addenda, being more recently issued, would prevail against both the original RFP and the Vendor's proposal in the event of an inconsistency, ambiguity, or conflict.

K. Signed Contract

To facilitate contract award and approval by the Legislative Contract Oversight Committee, Vendor is required to submit the signed contract and attachments contained in Appendix H with the proposal. These are the documents necessary to present to the Contract Review Committee for approval if the Vendor is selected to receive the contract.

L. Vendor's Signature

The proposal must be accompanied by the RFP Cover Sheet signed in ink by an individual authorized to legally bind the Vendor. The Vendor's signature on a proposal in response to this RFP guarantees that the offer has been established without collusion and without effort to preclude the State from obtaining the best possible supply or service. Proof of authority of the person signing the RFP response must be furnished upon request.

M. Offer in Effect for 90 Days

A proposal may not be modified, withdrawn or canceled by the Vendor for a 90-day period following the deadline for proposal submission as defined in the Schedule of Events, or receipt of best and final offer, if required, and Vendor so agrees in submitting the proposal.

N. State Not Responsible for Preparation Costs

The costs for developing and delivering responses to this RFP and any subsequent presentations of the proposal as requested by the State are entirely the responsibility of the Vendor. The State is not liable for any expense incurred by the Vendor in the preparation and presentation of their proposal or any other costs incurred by the Vendor prior to execution of a contract.

O. Proposal Guarantee

Each sealed response shall be accompanied by a proposal guarantee in the form of a cashier's check, other type bank certified check (personal or company checks are not acceptable), bank or postal money order or surety bond issued by a company authorized to do business within the State of Alabama. An irrevocable letter of credit may be acceptable if approved by the Medicaid Agency no later than 24 hours prior to proposal opening. The proposal guarantee shall be payable to the State of Alabama in the amount of $50,000, as a guarantee of good faith and to insure a firm proposal for contracting purposes for 90 calendar days after proposal due date. Proposal guarantees shall be returned to unsuccessful Vendors after 90 calendar days.

P. State's Rights Reserved

While the State has every intention to award a contract as a result of this RFP, issuance of the RFP in no way constitutes a commitment by the State to award and execute a contract. Upon a determination such actions would be in its best interest, the State, in its sole discretion, reserves the right to:

- Cancel or terminate this RFP;

- Reject any or all of the proposals submitted in response to this RFP;
- Change its decision with respect to the selection and to select another proposal;
- Waive any minor irregularity in an otherwise valid proposal which would not jeopardize the overall program and to award a contract on the basis of such a waiver (minor irregularities are those which will not have a significant adverse effect on overall project cost or performance);
- Negotiate with any Vendor whose proposal is within the competitive range with respect to technical plan and cost;
- Adopt to its use all, or any part, of a Vendor's proposal and to use any idea or all ideas presented in a proposal;
- Amend the RFP (amendments to the RFP will be made by written addendum issued by the State and will be posted on the RFP website);
- Not award any contract.

Q. Organization of Proposal

Vendors are encouraged to review Appendix A as a checklist to make sure that their proposal contains all relevant information. It is not necessary to submit a copy of Appendix A with the proposal.

Proposals must be in the following order:

- Overview
- Technical Requirement
- Integration and Interface
- Approach to HHS Interoperability
- Approach to ECST including the checklist,
- Approach to Privacy and Security Standards
- Documentation, Training and Pilot
- Understanding of Implementation Schedule and Deliverables
- Project Management Plan
- Corporate Background
- Pricing

R. Page Limit

Proposals are limited to no more than 100 pages, front and back. Attachments cannot exceed 50 pages front and back. There should be no more than 75 total sheets of paper submitted. Each response (including all copies thereof) shall be 1) clearly page-numbered on the bottom (center or right) of each page, 2) submitted in three-ring binders no larger than 2", and 3) use 8.5 x 11-inch paper and two (2)-sided copies. A type size of 11 points or larger shall be used.

Brochures or other presentations beyond that sufficient to present a complete and effective response are not desired. Audio and/or videotapes are not allowed. Elaborate artwork or expensive paper is not necessary or desired.

The State desires and encourages that proposals be submitted on recycled paper . While the appearance of proposals and professional presentation is important, the use of non-recyclable or non-recycled glossy paper is discouraged.

S. Failure to Comply with Instructions

The State may deem non-responsive, and thus disqualify from further consideration, any proposal that does not follow the instructions set out in this RFP or is missing any requested information.

T. Multiple Proposals

Vendors may only participate in a single proposal in response to this RFP, either as prime contractor or subcontractor. If multiple proposals are received in which a Vendor is proposed as either prime or subcontractor, all proposals including said Vendor will be deemed non-responsive and excluded from consideration.

U. Price Sheets

Vendors must respond to this RFP by utilizing the Vendor Price Sheets found in Appendix G. These price sheets will be used as the primary representation of each Vendor's cost/price and will be used extensively during proposal evaluations. Additional information should be included as necessary to explain in detail the Vendor's cost/price.

V. Submission of Proposals

Proposals must be sealed and labeled on the outside of the package to clearly indicate that they are in response to TFQ-2007-01. Proposals must be sent to the attention of the Project Director and received at the Agency as specified in the Schedule of Events. It is the responsibility of the Vendor to ensure receipt of the Proposal by the date specified in the Schedule of Events.

W. Copies Required

Vendors must submit one original Proposal with original signatures in ink and 15 hard copies, plus one electronic (Word format) copy of the Proposal on CD, jumpdrive or disc clearly labeled with the Vendor name.

Facsimile or electronic responses to requests for proposals will NOT be accepted.

X. Late Proposals

Regardless of cause, late proposals will not be accepted and will automatically be disqualified from further consideration. It shall be the Vendor's sole risk to assure delivery at the Agency by the designated time. Late proposals will not be opened and may be returned to the Vendor at the expense of the Vendor or destroyed if requested.

Y. Protest Procedures

Any Vendor filing a protest with regard to this procurement must lodge the protest within the timeframe prescribed in the Schedule of Events and strictly adhere to the procedures set out below:

1. Vendors protesting this procurement shall follow the procedure described herein. Protests that do not follow these procedures shall not be considered. This protest procedure constitutes the sole administrative remedy available to Vendors under this procurement.
2. All protests must be in writing and signed by the protesting party or an authorized Agent. The protest must state the grounds for the protest with the specific and complete statements of the actions being protested. Protesting parties must demonstrate as part of their protest that they made every reasonable effort within the schedule and procedures of this RFP to resolve the basis of their protest during the acquisition process. A description of the relief or corrective action being requested must also be stated. All protests shall be addressed to the Project Director.
3. Only protests stipulating an issue of fact concerning a matter of bias, discrimination or conflict of interest, or non-compliance with procedures described in the RFP document or ALMA policy shall be considered. Protests not based on procedural matters will not be considered.
4. In the event a protest may affect the interest of any Vendor, such Vendor(s) will be given an opportunity to submit its views and any relevant information on the protest to the Project Director
5. Following notice of the apparent successful vendor, parties that have submitted a proposal are allowed three business days to file a protest with the Agency. Such protests may be regarding issues of award, but all issues regarding the structure of the RFP or anything described within the RFP must have been previously filed as described above. After three business days, vendors waive the right to protest. Upon receipt of a protest, a review will be held by ALMA to review the procurement process utilized. This is not a review of proposals submitted or the evaluation of scores received. The review is to ensure ALMA policy and procedures were followed, all requirements were met, and all Vendors were treated equally and fairly. ALMA will then consider all the information available and render a written decision within ten (10) business days of receipt of the protest, unless additional time is required. If additional time is required, the protesting party will be notified of the delay. The filing of protest shall not prevent ALMA from executing a contract with any other vendor.

XIV. EVALUATION AND SELECTION PROCESS

A. Initial Classification of Proposals as Responsive or Non-responsive

All proposals will initially be classified as either “responsive” or “non-responsive”. Proposals may be found non-responsive at any time during the evaluation process or contract negotiation if any of the required information is not provided; or the proposal is not within the plans and specifications described and required in the RFP. If a proposal is found to be non-responsive, it will not be considered further.

Proposals failing to demonstrate that the Vendor meets the mandatory requirements listed in Appendix A will be deemed non-responsive and not considered further in the evaluation process (and thereby rejected).

While vendors are encouraged to submit innovative approaches, proposals must meet the minimum requirements specified to be considered.

B. Determination of Responsibility

The Project Director will determine whether a Vendor has met the standards of responsibility. In determining responsibility, the Project Director may consider factors such as, but not limited to, the vendor’s specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

C. Evaluation of Proposals

The evaluation committee will evaluate the remaining proposals and recommend whether to award the contract to the highest scoring Vendor or, if necessary, to seek discussion/negotiation of a best and final offer in order to determine the highest scoring Vendor. All responsive proposals will be evaluated based on stated evaluation criteria. In scoring against stated criteria, the State may consider such factors as accepted industry standards and a comparative evaluation of all other qualified RFP responses in terms of differing price, quality, and contractual factors. These scores will be used to determine the most advantageous offering to the State.

D. Completeness of Proposals

Selection and award will be based on the Vendor’s proposal and other items outlined in this RFP. Submitted responses may not include references to information located elsewhere, such as Internet websites or libraries, unless specifically requested by the State in this RFP. Information or materials presented by Vendors outside the formal response or subsequent discussion/negotiation of a “best and final offer,” if requested, will not be considered, will have no bearing on any award, and may result in the Vendor being disqualified from further consideration.

E. Opportunity for Additional Information

The State reserves the right to contact any Vendor submitting a proposal for the purpose of clarifying issues in that Vendor's proposal. Vendors should clearly designate in their proposal a point-of-contact for questions or issues that arise in the State's review of a Vendor's proposal.

F. Best and Final Offer

The "Best and Final Offer" is an option available to the State under the RFP process, which permits the State to request a "best and final offer" from one or more Vendors if additional information is required to make a final decision. Vendors may be contacted asking that they submit their "best and final offer," which must include any and all discussed and/or negotiated changes. The State reserves the right to request a "best and final offer" for this RFP, based on price/cost alone.

G. Evaluation Criteria

The evaluation committee will review and evaluate the offers according to the following criteria based on **a maximum possible value of 100 points**. The **References, Vendor Profile and Experience, Method of Providing Services, and Financial Stability** portions of the offer will be evaluated based on the following Scoring Guide, while the **Cost Proposal** will be evaluated based on the formula set forth below:

	Category	RFP Section	Point Value
References			**Pass/Fail**
A.	References Included with Vendor's Response	XII.D.	
Mandatory Vendor Requirements			**Pass/Fail**
A.	Vendor Experience Minimums Met & Documented	XII	
Vendor Profile and Experience		**10 % of points for a possible**	**10 points**
A.	Years and Applicability of Experience	XII	10
Vendor Solutions		**70% of points for a possible**	**70 points**
A.	Technical Requirements	III	15
B.	Integration and Interface Requirements	IV	15
C.	HHS Interoperability	V	15
D.	Electronic Clinical Support Tool	VI	15

D.	Project Management	X	10
Financial Stability			**Pass Fail**
A.	Financial Stability	XII.B.	Pass/Fail
Cost Proposal		**20% of points for a possible 20 points**	
A.	Cost Proposal	6.0	20

H. Evaluation and Selection Process

The evaluation process is designed to award the contract to the Vendor with the best combination of attributes based upon the evaluation criteria including, but not limited to, cost.

The Project Director shall manage the proposal evaluation process and maintain proposal evaluation records. The evaluation committee comprised of State staff and TFQ stakeholders shall be responsible for evaluating proposals. The sequence of events in the scoring process will be as follows:

- Removal of non-responsive or responsible proposals;
- Committee evaluation and scoring of responsive Vendor proposals to determine technical score;
- Project Director scoring of responsive Cost Proposals;
- Merging of Vendor Technical Proposal scores and Cost Proposal scores;
- Recommendation of Award.

Each member of the Evaluation committee shall evaluate all assigned areas and allocate points independent of other committee member input. Each evaluator shall use only whole numbers for scoring proposals.

The State reserves the right, at its sole discretion, to request clarifications of Vendor Informational Requirements or to conduct discussions for the purpose of clarification with any or all Vendors. The purpose of any such discussions shall be to ensure full understanding of the proposal. Discussions shall be limited to specific sections of the proposal identified by the evaluation committee. If held, the discussion shall be after initial evaluation of Vendor qualifications. If clarifications are made as a result of such discussion, the Vendor shall put such clarifications in writing.

I. Evaluation: Cost Proposal Scoring

Independent of the Vendor Technical Proposal Evaluation, the Project Director shall calculate scores for each Cost Proposal according to the following:

Lowest overall cost receives the maximum allotted points (20). All other proposals receive a percentage of the points available based on their cost relationship to the lowest cost.

Example: Total possible points for cost are 20.
Vendor A's cost is $20,000.
Vendor B's cost is $25,000.
Vendor A would receive 20 points,
Vendor B would receive 20 points ($20,000/$25,000) = 80% x 20 points = 16).

$$\frac{\text{Lowest Responsive Offer Total Cost}}{\text{This Vendor's Total Cost}} \times \text{Number of Available Points} = \text{Award Points}$$

XV. GENERAL TERMS AND CONDITIONS

A. General

This RFP and Contractor's response thereto shall be incorporated into a contract by the execution of a formal agreement. The contract and amendments, if any, are subject to approval by the Governor of the State of Alabama.

The contract shall include the following:

1. Executed contract,
2. RFP, and any amendments thereto,
3. Contractor's response to the RFP, and shall be construed in accordance with and in the order of the applicable provisions of:
   - Title XIX of the Social Security Act, as amended and regulations promulgated hereunder by HHS and any other applicable federal statutes and regulations
   - The statutory and case law of the State of Alabama
   - The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
   - The Medicaid Administrative Code
   - Medicaid's written response to prospective Vendor questions

B. Compliance with State and Federal Regulations

Contractor shall perform all services under the contract in accordance with applicable federal and state statutes and regulations. Medicaid retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same may be amended from time to time.

C. Term of Contract

The contract shall take effect when signed by all parties, and shall terminate on September 30, 2009. Medicaid shall have a one-year option for extending this contract on the same terms as for the original period, such option to be exercised by notice to Contractor in writing no less than sixty (60) days prior to the beginning of the option year.

D. Contract Amendments

No alteration or variation of the terms of the contract shall be valid unless made in writing and duly signed by the parties thereto. The contract may be amended by written agreement duly executed by the parties. Every such amendment shall specify the date its provisions shall be effective as agreed to by the parties.

The contract shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, that materially affects the operation of the Alabama Medicaid

Program or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such substantial change.

E. Confidentiality

Contractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the contract, as confidential information to the extent confidential treatment is provided under State and Federal laws including 45 CFR §160.101 – 164.534. Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this contract.

Contractor shall insure safeguards that restrict the use or disclosure of information concerning individuals to purposes directly connected with the administration of the Plan in accordance with 42 CFR Part 431, Subpart F, as specified in 42 CFR § 434.6(a)(8). Purposes directly related to the Plan administration include:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan.

Pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), the successful Contractor shall sign and comply with the terms of a Business Associate agreement with the Agency (Appendix H).

F. Security and Release of Information

Contractor shall take all reasonable precautions to insure the safety and security of all information, data, procedures, methods, and funds involved in the performance under the contract, and shall require the same from all employees so involved. Contractor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of Medicaid. This provision covers both general summary data as well as detailed, specific data. Contractor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of Medicaid. All requests for program data shall be referred to Medicaid for response by the Commissioner only.

G. Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as $5,000 or imprisonment for as long as five years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security

information may also result in an award of civil damages against the officer or employee in an amount not less than $1,000 with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, it is incumbent upon the contractor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a (1) (1), which is made applicable to contractors by 5 USC 552a (m) (1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

H. Contract a Public Record

Upon signing of this contract by all parties, the terms of the contract become available to the public pursuant to Alabama law. Contractor agrees to allow public access to all documents, papers, letters, or other materials subject to the current Alabama law on disclosure. It is expressly understood that substantial evidence of Contractor's refusal to comply with this provision shall constitute a material breach of contract.

I. Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy or a company or corporate reorganization pursuant to the Bankruptcy Act may constitute default by Contractor effective the date of such filing. Contractor shall inform Medicaid in writing of any such action(s) immediately upon occurrence by the most expeditious means possible. Medicaid may, at its option, declare default and notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor and the Surety (if any) for Contractor’s Performance Guarantee.

J. Termination for Default

Medicaid may, by written notice, terminate performance under the contract, in whole or in part, for failure of Contractor to perform any of the contract provisions. In the event Contractor defaults in the performance of any of Contractor’s material duties and obligations, written notice shall be given to Contractor specifying default. A copy of the written notice shall be sent to the Surety (if any) for Contractor’s Performance Guarantee. Contractor shall have 10 calendar days, or such additional time as agreed to in writing by Medicaid, after the mailing of such notice to cure any default. In the event Contractor does not cure a default within 10 calendar days, or such additional time allowed by Medicaid, Medicaid may, at its option, notify Contractor in writing that performance under the contract is terminated and proceed to seek appropriate relief from Contractor and any Surety.

K. Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under the contract is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If Medicaid, in its sole discretion, deems at any time during the term of the contract that monies lawfully applicable to this agreement shall not be available for the remainder of the term, Medicaid shall promptly notify Contractor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be cancelled without penalty to Medicaid, State or Federal Government.

L. Termination for Convenience

Medicaid may terminate performance of work under the Contract in whole or in part whenever, for any reason, Medicaid, in its sole discretion determines that such termination is in the best interest of the State. In the event that Medicaid elects to terminate the contract pursuant to this provision, it shall so notify the Contractor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, Contractor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Contractor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

M. Force Majeure

Contractor shall be excused from performance hereunder for any period Contractor is prevented from performing any services pursuant hereto in whole or in part as a result of an act of God, war, civil disturbance, epidemic, or court order; such nonperformance shall not be a ground for termination for default.

N. Nondiscriminatory Compliance

Contractor shall comply with Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment.

O. Small and Minority Business Enterprise Utilization

In accordance with the provisions of 45 CFR Part 74 and paragraph 9 of OMB Circular A-102, affirmative steps shall be taken to assure that small and minority businesses are utilized when possible as sources of supplies, equipment, construction, and services.

P. Worker's Compensation

Contractor shall take out and maintain, during the life of this contract, Worker's Compensation Insurance for all of its employees under the contract or any subcontract thereof, if required by state law.

Q. Employment of State Staff

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the contract any professional or technical personnel, who are or have been in the employment of Medicaid during the previous twelve (12) months, except retired employees or contractual consultants, without the written consent of Medicaid.

R. Share of Contract

No official or employee of the State of Alabama shall be admitted to any share of the contract or to any benefit that may arise there from.

S. Performance Guarantee

In accordance with Alabama Code §41-16-28, Contractor shall post a performance guarantee in the form of a cashiers check, other type bank certified check (personal or company checks are not acceptable), bank or postal money order or surety bond issued by a company authorized to do business within the State of Alabama. An irrevocable letter of credit may be acceptable if approved in advance by the Division of Purchasing and Medicaid. The performance guarantee shall be in an amount equal to $200,000 under this contract. The guarantee shall be in force during the entire term of the contract (including any extensions), and shall be conditioned on faithful performance of all contractual obligations.

T. Indemnification

Contractor shall hold harmless, defend and indemnify the State as to any penalties or federal recoupment and any interest incurred by reason of any Title XIX noncompliance due to the fault of Contractor and/or any subcontractors. The term "Title XIX noncompliance" shall be construed to mean any failure or inability of Medicaid to meet the requirements of Title XIX of the Social Security Act or of the Together for Quality Grant, due to an act or omission of Contractor or subcontractor and/or any regulations promulgated by the federal government in connection therewith. Contractor shall be liable and agrees to be liable for and shall indemnify, defend, and hold the State and its officers, employees and agent harmless from all claims, suits, judgments or damages, including court costs and attorney fees, arising out of or in connection with this contract due to negligent or intentional acts of omissions of the Contractor and/or any subcontractors. Contractor shall hold the State harmless from all subcontractor liabilities under the terms of this contract.

Contractor agrees to indemnify, defend, and hold harmless the State, its officers, agents, and employees from:

1. Any claims or losses attributable to a service rendered by Contractor or any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract regardless of whether the State knew or should have known of such improper service, performance, materials or supplies unless otherwise specifically approved by the State in writing in advance.

2. Any claims or losses attributable to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes, of Contractor, its officers, employees, or subcontractors in the performance of the contract, regardless of whether the State knew or should have known of such erroneous or negligent acts.

3. Any failure of Contractor, its officers, employees, or subcontractors to observe Alabama laws, including, but not limited to, labor laws and minimum wage laws, regardless of whether the State knew or should have known of such failure.

4. If at any time during the operation of this contract, the State gains actual knowledge of any erroneous, negligent, or otherwise wrongful acts by Contractor, its Officers, employees, or subcontractors, the State agrees to give Contractor written notice thereof. Failure by the State to give said notice does not operate as a waiver of Contractor's obligations to the State, or a release of any claims the State may have against Contractor.

U. Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties.

V. Warranties Against Broker's Fees

Contractor warrants that no person or selling agency has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission percentage, brokerage, or contingency fee excepting bona fide employees. For breach of this warranty, Medicaid shall have the right to terminate the contract without liability.

W. Novation

In the event of a change in the corporate or company ownership of Contractor, Medicaid shall retain the right to continue the contract with the new owner or terminate the contract. The new corporate or company entity shall agree to the terms of the original contract and any amendments thereto. During the interim between legal recognition of the new entity and Medicaid execution of the novation agreement, a valid contract shall continue to exist between Medicaid and the original Contractor. When, to Medicaid's satisfaction, sufficient evidence has been presented of the new owner's ability to perform under the terms of the contract, Medicaid may approve the new owner and a novation agreement shall be executed.

X. Employment Basis

It is expressly understood and agreed that Medicaid enters into this agreement with Contractor and any subcontractor as authorized under the provisions of this contract as an independent Contractor on a purchase of service basis and not on an employer-employee basis and not subject to State Merit System law.

Y. Disputes and Litigation

Except in those cases where the proposal response exceeds the requirements of the RFP, any conflict between the response of Contractor and the RFP shall be controlled by the provisions of the RFP. Any dispute concerning a question of fact arising under the contract which is not disposed of by agreement shall be decided by the Commissioner of Medicaid.

Any litigation brought by Medicaid or Contractor to enforce any provision of the contract shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision shall not be deemed an attempt to confer any jurisdiction on these courts which they do not by law have, but is a stipulation and agreement as to forum and venue only.

Z. Records Retention and Storage

In accordance with 45 CFR §74.164, Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of the State or Federal Government has begun but is not completed at the end of the three year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution.

AA. Inspection of Records

Contractor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representatives shall have the right during business hours to inspect and copy Contractor's books and records pertaining to contract performance and costs thereof. Contractor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. Contractor may require that a receipt be given for any original record removed from Contractor's premises.

BB. Use of Federal Cost Principles

For any terms of the contract which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under the contract shall be in accordance with 48 CFR, Chapter 1, Part 31. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Contractor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

CC. Payment

Contractor shall submit to Medicaid a detailed invoice for compensation for the deliverable and/or work performed. Invoices should be submitted to the Project Director. Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation.

DD. Notice to Parties

Any notice to Medicaid under the contract shall be sufficient when mailed to the Project Director. Any notice to Contractor shall be sufficient when mailed to Contractor at the address given on the return receipt from this RFP or on the contract after signing. Notice shall be given by certified mail, return receipt requested.

EE. Disclosure Statement

The successful Vendor shall be required to complete a financial disclosure statement (Appendix H) with the executed contract.

FF. Subcontracting

The contract shall not be assigned without written consent of Medicaid. Contractor may subcontract for the professional services necessary for the completion and maintenance of this contract and for the performance of its duties under this contract with advance written approval of both the subcontracted function and the subcontractor by Medicaid. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to the requirements of the contract relevant to the service to be performed. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this RFP. Contractor shall at all times remain responsible for the performance by subcontractors approved by Medicaid. Contractor's performance guarantee and Contractor's responsibility for damages shall apply whether performance or non-performance was by Contractor or one of its subcontractors. Medicaid shall not release Contractor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of Contractor, even if such subcontractor was approved by Medicaid as provided above. Contractor shall give Medicaid notice in writing by registered mail of any action or suit made against Contractor by any subcontractor or vendor, which, in the opinion of Contractor, may result in litigation related in any way to this contract with the State of Alabama.

If a proposing Vendor intends to use subcontractors, the Vendor must identify in the proposal the names of the subcontractors, portions of the work the subcontractors will perform, and background and experience qualifications as set out in Section XII. A Vendor's failure to provide this information may cause the State to consider its proposal non-responsive and reject it.

GG. Liquidated Damages

Contractor shall be liable for any penalties and late deliverables to include any disallowance of grant funds incurred by Medicaid due to Contractor's failure to comply with the terms of the contract. Imposition of liquidated damages is at the sole discretion

of Medicaid, is in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.

Contractor is required to submit deliverables for approval five (5) business days prior to due date.

Written notification of each failure to meet contractual requirements shall be given to the Contractor. The imposition of liquidated damages is not in lieu of any other remedy available to the State. Medicaid shall withhold from Contractor reimbursements the amounts necessary to satisfy any damages imposed.

A decision by Medicaid not to exercise this damage clause in a particular instance shall not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages. The State may, at its sole discretion, return all or a portion of any liquidated damages collected, as an incentive to the Contractor for prompt and lasting correction of performance problems.

a) Implementation Task Completion Damages

Twenty-five hundred dollars ($2500) damages per work day, or any part thereof, shall be assessed for each of the first ten calendar days of delay in meeting a task completion date. Three thousand dollars ($3,000) damages per work day, or any part thereof, shall be assessed for each of the next 30 calendar days of delay. Up to five thousand dollars ($5,000) damages per work day, or any part thereof, shall be assessed for each additional day of delay after that.

b) Delivery of Reports Damages

Medicaid shall impose on Contractor liquidated damages of five hundred dollars ($500) per business day for Contractor's failure to furnish a required report in an accurate, complete, and usable form to Medicaid on or before the due date for such report, or as extended by written agreement with Medicaid. Due dates shall be as designated by the State. This assessment shall begin on the workday following the due date and continue until such time as Contractor furnishes Medicaid with the report(s) in an acceptable form. Receipt of inaccurate, incomplete and/or unusable reports shall not release Contractor from damages under this provision.

c) ECST System Availability Damages

Five hundred dollars ($500) per hour shall be assessed when the ECST is not available for end-users for greater than one hour in a day, other than scheduled or Medicaid-approved down time.

d) Presentations

Five thousand dollars ($5,000) per occurrence of presentations to groups/associations or others regarding this contract and work hereunder without prior approval of Medicaid shall be assessed.

e) Failure to Safeguard Information

Five hundred dollars ($500) per violation of failure to safeguard confidential information of providers, recipients or the Medicaid program plus any penalties incurred by Medicaid for said infractions.

f) Failure to Respond to End-User Inquiries

One hundred dollars ($100) per occurrence of Contractor not responding to end-user inquiries for pilot enrollment and/or help-desk inquiries within one business day of contact shall be assessed.

HH. Limited Liability

Damages incurred by the State as a result of the Contractor or any of its Subcontractors shall be limited to 150% of the total contract cost.

II. Cooperation

Effective operation of the Alabama Medicaid Program shall require close cooperation between Medicaid and Contractor. To this end, the parties agree to work mutually in solving operational problems. Contractor shall make known and fully describe to Medicaid, in writing, any difficulties encountered that threaten required performance or when such a potential exists. Such difficulties may include, but not be limited to, system "down" times, scheduling problems, meeting reporting requirements, accuracy of data, etc. If Contractor determines that Medicaid's input or direction is required to resolve the difficulties, such an explanation describing the desired input along with any applicable timetables and projected corrections shall be included in a report. Contractor shall notify the Medicaid Project Director by telephone within one (1) working day of discovery of any problem which has already occurred, or within one (1) working day of the identification of potential problems that threaten required performance. All telephone notices shall be followed up in writing, including any corrective action taken.

JJ. Access to State of Alabama Staff

The Contractor's access to State of Alabama personnel will be as needed. However, the competency/sufficiency of State of Alabama staff will not be reason for relieving the Contractor of any responsibility for failing to meet required deadlines or for producing non-acceptable deliverables.

KK. Conformance With Contract

No alteration of the terms, conditions, delivery, price, quality, quantities, or specifications of the contract shall be granted without prior written consent of the State. Supplies delivered which do not conform to the contract terms, conditions, and specifications may be rejected and returned at the Contractor's expense.

LL. Debarment

Contractor hereby certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any Federal department or agency. (Appendix H)

MM. Ownership

The Contractor agrees that in conjunction with 45 CFR 95.617(a, b), the State and ALMA reserve a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the products developed under this contract, and to authorize others to do so.

NN. Not to Constitute a Debt of the State

Under no circumstances shall any commitments by Medicaid constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of this Contract, be enacted, then that conflicting provision in the contract shall be deemed null and void. The Contractor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

OO. Alternative Dispute Resolution

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through the Attorney General's Office of Administrative Hearings or where appropriate, private mediators.

APPENDIX A: PROPOSAL COMPLIANCE CHECKLIST

NOTICE TO VENDOR:

It is highly encouraged that the following checklist be used to verify completeness of Proposal content. It is not required to submit this checklist with your proposal.

Vendor Name

Project Director Review Date

*Proposals for which **ALL** applicable items are marked by the Project Director are determined to be compliant for responsive proposals.*

*The Evaluation Committee must review any applicable items that are **not** marked to determine if:*

- *the proposal sufficiently meets basic requirements;*
- *the State shall request clarification(s) or correction(s); or,*
- *the State shall deem the proposal non-responsive and reject it.*

The Proposal Evaluation Team must attach a written determination for each applicable item that is NOT marked.

☒ IF CORRECT	BASIC PROPOSAL REQUIREMENTS
☐	1. Physical Format and Section Content conforms to Requirements
☐	2. Vendor ‘s proposal received on time at correct location.
☐	3. Required number of Vendor Proposal copies received.
☐	4. Vendor submitted proposal in an electronic format.
☐	5. The Proposal includes a completed and signed RFP Cover Sheet.
☐	6. Vendor submitted signed contract and attachments
☐	7. The Proposal is a complete and independent document, with no references to external documents or resources.
☐	8. Vendor attended the mandatory Pre-Proposal conference.

☐	9. Vendor submitted the required Letter of Intent to submit a proposal.
☐	10. Vendor submitted signed acknowledgement of any and all addenda to RFP.
☐	11. Each Proposal section is structured and labeled based on the proposal organization outlined in the RFP.
☐	12. The Proposal includes written confirmation that the Vendor understands and shall comply with all of the provisions of the RFP.
☐	13. The Proposal includes a brief Statement attesting that it meets all mandatory Vendor requirements.
☐	14. The Proposal includes 3 client references (with all identifying information in specified format and order).
☐	15. The Proposal includes a corporate background.
☐	16. The Proposal includes a detailed description of the technical requirements, including technical diagrams and architecture.
☐	17. The Proposal includes a detailed listing of equipment necessary.
☐	18. The Proposal includes a detailed listing of software necessary.
☐	19. The Proposal includes the ECST proposed solution worksheet.
☐	20. The Integration and Interface Checklist is included.
☐	21. The Exchange Standards Checklist is included.
☐	22. HHS Interoperability is addressed.
☐	23. The Proposal includes the Privacy and Security checklist.
☐	24. The Proposal includes a narrative of the Vendor's proposed Project Management methodology with a Project Plan including deliverables.
☐	25. The Proposal includes required balance sheet and financial chart.
☐	26. The Proposal includes completed and signed Price Sheets.

APPENDIX B: DEFINITIONS

Centers for Medicare and Medicaid Services (CMS): The CMS, through the Health and Human Services Administration, seeks to protect and improve beneficiary health and satisfaction; foster appropriate and predictable payments and high quality care; promote understanding of CMS programs among beneficiaries, the healthcare community, and the public; promote the fiscal integrity of CMS programs and be an accountable steward of public funds; foster excellence in the design and administration of CMS programs and provide leadership in the broader healthcare marketplace to improve health.

Certification Commission for Healthcare Information Technology (CCHIT): A group whose mission is to accelerate the adoption of robust interoperable HIT throughout the US healthcare system by creating an efficient, credible, sustainable mechanism for the certification of HIT products.

Decision Support (Clinical): Any system designed to improve clinical decision making related to diagnostic or therapeutic processes of care. CDS systems thus address activities ranging from the selection of drugs (i.e., the optimal antibiotic choice given specific microbiologic data or diagnostic tests) to detailed support for optimal drug dosing and support for resolving diagnostic dilemmas.

Disease Management: A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

End-User: A clinician or other healthcare professional that is accessing the information available through the HIS.

Electronic Clinical Support Tool (ECST): The ECST will serve as *Together for Quality's* clinical decision support tool. The ECST will extract pertinent information out of the Personal Data Hub. The ECST is intended to include Medicaid's preferred drug list, generic and therapeutic options, prior authorization requirements, medication history and clinical support at the point-of-care. Advanced e-health functions to include the ability to e-prescribe and obtain a real-time response for prescriptions, as well as an electronic provider profile tool to include peer comparisons based on patient acuity and health outcome measures will also be included in the ECST.

Electronic Health Record (EHR): A real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health

disease surveillance and reporting. In *Together for Quality*, data from claims, immunization records, laboratory results and prescriptions will be used as the initial data set which, when pulled together for an individual Medicaid beneficiary, will be considered the electronic health record.

Electronic Medical Record (EMR): A computerized practice management system providing real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access. A motivation for healthcare providers to implement this technology derives from the need for medical outcome studies, more efficient care, speedier communication among providers, and easier management of health plans.

Electronic Prescribing (eRx): A type of computer technology whereby physicians use handheld or personal computer devices to review drug and formulary coverage and to transmit prescriptions to a printer or to a local pharmacy. E-prescribing software can be integrated into existing clinical information systems to allow physician access to patient-specific information to screen for drug interactions and allergies.

Health Information Exchange (HIE): The mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care.

Health Information Technology (HIT): The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.

Health Insurance Portability and Accountability Act (HIPAA): Enacted by the U.S. Congress in 1996. According to CMS, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, the Administrative Simplification provisions, requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans, and employers.

Interoperability: The ability to exchange and use information (usually in a large heterogeneous network made up of several local area networks). Interoperable systems reflect the ability of software and hardware on multiple machines from multiple vendors to communicate.

Master Patient Index (MPI): Index referencing all patients relating to an area or organization and acting as a source of patient /service user demographic data for other linked services and systems.

Open Systems: Computer systems that provide some combination of interoperability; portability and open software standards.

Patient Data Hub (PDH): As a core piece of *Together for Quality's* health information system, the Alabama Medicaid Agency intends to develop an interoperable patient data hub (PDH). The PDH will serve as the foundational architecture for data exchange between all stakeholders, public and private,

responsible for all facets of the health care delivery system, providing secure real time access to individual health information, claims, immunization records, prescription data and laboratory results. This system will pave the way for outcome based improvement of patient care and will provide significant components of data for Medicaid's future pay for performance and disease management efforts.

Practice Management System (PMS): Part of the medical office record. It carries the financial, demographic, and non-medical information about patients. This information frequently includes the patient's name, patient's federal identification number, date of birth, telephone numbers, emergency contact person, alternate names for the patient, insurance company, subscriber information for an insurance company, employer information, information to verify insurance eligibility, information to qualify for lower fees, and provider numbers to process medical claims.

Record Locater Service (RLS): The Record Locator Service is the only new piece of infrastructure required by the Health Information Environment. The RLS is subject to privacy and security requirements, and is based on open standards set by the Standards and Policy Entity. The RLS holds information authorized by the patient about where authorized information can be found, but not the actual information the records may contain. It thus enables a separation, for reasons of security, privacy, and the preservation of the autonomy of the participating entities, of the function of locating authorized records from the function of transferring them to authorized users. RLSs are operated by multi-stakeholder collaboratives at each sub-network and are built on the current use of Master Patient Indices.

Terminology Management: The ability of the system to manage disparate terminologies and vocabularies received from source systems and map the concepts to common standard terminologies. This capability ensures the preservation of the semantics of the source data and allows for the management of disparate terminology concepts and versioning of the vocabularies in the clinical data repository.

Use Case: A use case is a technique for capturing the potential requirements of a new system or software change. Each use case provides one or more scenarios that convey how the system should interact with the end user or another system to achieve a specific business goal. The use case should contain all system activities that have significance to the users. A use case can be thought of as a collection of possible scenarios related to a particular goal, indeed, the use case and goal are sometimes considered to be synonymous.

APPENDIX C: DATA BASE DESCRIPTIONS

Immunization Data

The Alabama Department of Public Health developed and currently maintains IMMPRINT which is an Oracle relational database containing numerous tables, with the main ones being demographics of the patients, the vaccines, and the actual immunization transactions. It is web-based and is accessible by health providers who have been given a user ID and a password. It contains data from the Medicaid MMIS, Blue Cross of Alabama, and the Health Department clinics. For more information visit: www.adph.org/immunizations.

Demographic, Claims, and Lab Data

For the last three years Alabama Medicaid has been transmitting demographic and pharmacy claims data to BCBS of Alabama for incorporation into the InfoSolutions® data repository. Medicaid is actively testing the addition of medical claims to the transfer process. Lab data from most laboratories is currently available in the database. InfoSolutions® is a DB2 relational database containing numerous tables, with the main ones being patient demographics, physician and hospital claim data, lab data, and medication ordered and filled transactions. The data is stored in the InfoSolutions® database and is accessible via a web application and vendor interfaces. The e-Prescribing application can be accessed in a web or personal digital assistant. The information can be accessed by providers who have been given a user ID and a password. The database contains data from the Medicaid MMIS, FEP, Blue Cross and Blue Shield of Alabama, multiple lab sources, multiple hospital/clinic sources and the Alabama Department of Public Health. For more information visit: www.infosolutions.net.

Online Disaster Network

This process is being re-evaluated by Southern Governor's Association (SGA) pending clarification of current state capacities.

Emergency Patient Information (EPI)

EPI is a SQL server relational database containing numerous tables, consisting of patient demographics, emergency contact information, medical conditions, allergies, surgeries, healthcare providers, immunizations and medications. EPI contains data entered by the patient, is web-based and is accessible by providers who have been provided a rescue login and by individual patients who have registered. For more information visit: www.bcbsal.org.

AIMS

The Alabama Department of Senior Services currently has a client/server application in place called Aging Information Management System (AIMS). AIMS is a comprehensive database application for tracking clients and services for Alabama's Aging Network. The system was designed originally out of a need to set up one central area to house client information in order track clients, the services they receive and provider real-time reporting. Prior to the development of this system, information had to be gathered from several different sources and manually entered. The database has real-time data as well as cumulative data (it maintains history files for any services received). It is an established and proven database that has been in existence since mid- 1990s. It serves as a case management, program monitoring, auditing, and billing tool.

Pharmacy Prior Authorization (PA)

Health Information Designs, Inc. developed and currently maintains RxPert which is a Progress relational database containing numerous tables needed for a prior authorization system. RxPert is web-based and interfaces with the Alabama MMIS system via 3270 transactions and NCPDP P4 transactions. The system checks for various parameters electronically and also has the ability for manual interaction. It contains data from the Alabama Medicaid MMIS. For more information visit: www.hidmedicaid.com**.**

Health Records for Uninsured Individuals

In partnership with the Alabama Primary Health Care Association and the Alabama Hospital Association, the commitment has been established to begin collecting data for uninsured individuals from Federally Qualified Health Centers, Rural Health Clinics, and hospital emergency rooms for access through the ECST. This database does not currently exist and the vendor solution should address the incorporation of this data into the ECST.

APPENDIX D: DATA ELEMENTS FOR THE ECST

Note: The following table lists variables that the ALMA would like to see included in the Electronic Clinical Support Tool (ECST). These data elements are needed for provider use, for Agency quality measurement and for use in generating a public health surveillance database in later phases of the process. It is the ALMA's desire that **all** data elements indicated below be included but in case inclusion of all variables of interest is not feasible, the "Priority" column distinguishes between variables deemed to be of high priority and those deemed to be of medium priority. There are several general requirements; elements should be sortable, provider entered elements are not required; fields with no information should autopopulate with default values, inactive diagnoses should be suppressed unless more history is requested, procedures should display the 10 most recent chronologically but allow expansion or the ability to review more of the history and items identified as "modifiable" should have default set as suppressed unless activated.

Category	***Element***	***Priority***		***Comments***	***Source of Data***
		High	***Medium***		
Demographics	SSN		X	For an aggregated database, SSN would be useful only if legislation permitting its use for linking records were in place. Even if such legislation were in place, SSN alone would not be sufficient for linking records.	InfoSolutions®
	DOB	X		Needed to help assure unduplicated counts of individuals & to calculate age.	InfoSolutions®
	DOD		X	Significant delays occur in obtaining this information. Providers should be allowed to enter this information but it should not become part of the permanent record until verified by ALMA..	Provider Entered
	First, middle, & last name	X		Needed initially to help assure unduplicated counts of individuals	InfoSolutions®
	Gender	X			InfoSolutions®
	State	X			InfoSolutions®

Category	*Element*	*Priority*		*Comments*	*Source of Data*
		High	*Medium*		
	Race	X			InfoSolutions®
	Marital status		X		InfoSolutions®
	Primary, secondary, & tertiary insurance info	X			InfoSolutions®
	County of Residence	X			InfoSolutions®
	Emergency contact information	X			BCBS of Alabama EPI System
	Phone number(s); home, work, cell	X			InfoSolutions®
	Scanned image of drivers license, insurance cards		X		InfoSolutions®
	Photograph of patient		X		InfoSolutions®
Medications	Date Ordered	X		Captured only when ePrescribing is used to order medications.	
	Date filled	X			InfoSolutions®
	Drug name	X			InfoSolutions®
	Strength	X			InfoSolutions®
	Dosing	X			InfoSolutions®
	Quantity	X			InfoSolutions®
	Prescriber	X			InfoSolutions®
	Package/Dosing Form	X			InfoSolutions®
	Number of Refills	X			InfoSolutions®
	Pharmacy Name	X			InfoSolutions®
	Diagnosis	X		Any kind of diagnosis—whether in the form of ICD-9 codes, ICD-10 codes, or SNOMED with a description in words—is of high priority for **ALL**	InfoSolutions®

Category	*Element*	*Priority*		*Comments*	*Source of Data*
		High	*Medium*		
				records, regardless of type of visit or claim and not just the codes for the diseases of focus. System must be able to map one terminology to another. Allow medication specific diagnoses to be entered (when available) by the prescriber or pharmacy.	
Problems/Symptoms/ Diagnoses	Date	X		Allows the recording of chief complaint and additional problems with 'Inactive' and 'Active' status noted. Display 'Active' and allow 'Inactive' to be pulled up upon request.	Provider Entered
	Problem / symptom	X		Include ICD-9 codes when appropriate/available	Provider Entered
Vital signs	Date	X			Provider Entered
	BP, Pulse, Resp, Weight, Height, Head Circumference, Waist Circumference	X		**Modifiable** by provider and sortable so that some items are not displayed e.g. head circumference for adults and waist circumference for children. Calculates BMI automatically when required information is entered whether kilograms/pounds or centimeters/inches entered.	Provider Entered
Social history	Tobacco, Alcohol, other substance use (indicate years of	X			Provider Entered

Category	Element	Priority		Comments	Source of Data
		High	Medium		
	use)				
	Children		X		Provider Entered
	Occupation		X		Provider Entered
	Marital Status		X		Provider Entered
	Religion		X		Provider Entered
	Education		X		Provider Entered
Family History	Father		X	Age (if deceased age at time of death), cause of death, major illnesses	Provider Entered
	Mother		X	Age (if deceased age at time of death), cause of death, major illnesses	Provider Entered
	Siblings		X	Age(s) (if deceased age at time of death), cause of death, major illnesses	Provider Entered
	Grandparents Maternal Paternal		X	Age (if deceased age at time of death), cause of death, major illnesses	Provider Entered
	Children		X	Age (if deceased age at time of death), cause of death, major illnesses	Provider Entered
	Congenital disorders		X	Condition,	Provider Entered
	Allergies or asthma		X	Agent and reaction type	Provider Entered
	Cancer		X	List each occurrence and Location, Type (if known) and relationship (maternal aunt, 1st cousin, etc.)	Provider Entered
	Mental illness		X	Condition, relationship	Provider Entered

Category	*Element*	*Priority*		*Comments*	
		High	*Medium*		
Procedures	Date	X			InfoSolutions®
	Procedure description	X			InfoSolutions®
	Results		X		InfoSolutions®
	Proc code qualifier		X		InfoSolutions®
	Proc code	X		Any procedure code not captured in the E/M, Lab and Radiology ranges including HCPCS codes.	InfoSolutions®
Immunizations	Admin date	X			IMMPrint Registry
	Description	X			IMMPrint Registry
	# in series	X		This would not need to be an original element, but should be derived through programming.	
	CPT code	X			IMMPrint Registry
	"Med Not Given"		X	Include ability to indicate that an immunization is not given and the reason not given.	IMMPrint Registry
	ICD-9	X		ICD-9 and a field to allow for ICD-10 codes are of high priority for ALL records, regardless of the type of visit or claim.	IMMPrint Registry
Allergies and Adverse Reactions	Agent(s)	X		Drugs, foods and other agents	Provider Entered
	Record date		X		Provider Entered
	Reaction		X		Provider Entered
	Status		X		Provider Entered
	Reaction 2, 3, etc		X		Provider Entered
	Status date		X		Provider Entered

Category	*Element*	*Priority*		*Comments*	
		High	*Medium*		
Inpatient Hospital stay	Date	X			InfoSolutions®
	Hospital name	X			InfoSolutions®
	Diagnosis - D	X		Any kind of diagnosis—whether in the form of ICD-9 codes, ICD-10 codes, and a description in words—is of high priority for ALL records, regardless of type of visit or claim.	InfoSolutions®
	Procedure - P	X			InfoSolutions®
	Discharge Summary		X		Provider Entered
	Plan Codes		X		
	Discharge date	X			X
	Admit date	X			X
Radiology	Date		X		InfoSolutions®
	Test name		X		InfoSolutions®
	Procedure code		X	Code range (70010-79999)	InfoSolutions®
	Results		X	Normal ranges should be displayed.	
	Abnormal flag		X		

APPENDIX E: USE CASE OF ECST FUNCTIONAL REQUIREMENTS

This narrative provides an example to more clearly define the functional requirements and informational needs identified by the TFQ Clinical Workgroup and is based on the assumption that the ECST is fully implemented and all objectives, tasks and activities have been completed.

Storyboard:
Jane Doe is a 30 y/o patient presenting to Dr. Smith's primary care office for a slight fever and uncontrolled wheezing. Upon registering the patient into the clinic's EMR system, the clerk notes her insurance provider, eligibility status, her history of chronic asthma and notifies Nurse Nightingale.

Upon accessing patient's record in the EMR system, Nurse Nightingale identifies several alerts; no pap smear in the past year and no flu shot identified in the EHR. Nurse Nightingale confirms that Ms. Doe has not had a flu shot or pap. She enters her chief complaint and vital signs into the EMR. The EMR automatically displays the guidelines for asthma and indicates the assessments needed. It displays Ms. Doe's medication profile which lists all active medications indicating dates ordered and filled.

Dr. Smith reviews his most current Provider Profiler and notes that he is performing above his peers on most indicators including those for asthma. Dr. Smith is also able to see that Jane Doe is on all medications recommended by the current guidelines. Dr. Smith evaluates Jane Doe and enters the clinical history and findings into the EMR system and then goes on to enter orders for several medical interventions. While in the office, Jane Doe receives a nebulizer treatment as well as a single dose of oral prednisone. Also, oxygen saturation testing is performed using a pulse oximeter; pulmonary function is checked using a peak flow meter; and a complete blood count (CBC) and a chest x-ray (CXR) are taken to rule out pneumonia.

Upon accessing the patient's record, Dr. Smith notes that Jane Doe has been previously seen by an Allergist and another primary physician during the past two months. He also notes that she was seen in the emergency room two days before and notes that these medications present in the medication list were filled and while performing a medication reconciliation process, he finds that Jane Doe has been refilling her asthma controller medication on a regular basis.

Noting an improvement of Jane Doe's symptoms after the medications and an unremarkable CBC and CXR, Dr. Smith writes prescriptions using the online ePrescribing function. Although the tool provides the option to print the prescriptions, Dr. Smith transmits the prescriptions electronically to the pharmacy. When verifying formulary/drug file alternatives, Dr. Smith notes PA requirements and electronically submits the necessary PA form which is electronically processed and approved.

Jane Doe is sent home on several prescriptions, which include albuterol MDI, prednisone tablets, and a refill of her montelukast tablets. She also receives the Flu vaccine before she goes home. She is advised to return to the clinic if she gets worse or does not feel better in the next 3 days and a visit is scheduled for her annual pap smear and for follow-up. Jane Doe goes straight to a local pharmacy, where her prescriptions are waiting for her. Her symptoms are better within 3 days.

APPENDIX F: QI MEASURES

Diabetes QI Measures (Adult and Pediatric)

1. HbA1C – percentage of patients who have had at least one HbA1C during 12 month review period and percentage of patients who have had two or more HbA1Cs during the 12 month review period **(Children and Adults)**
2. Lipid Management – percentage of patients who received at least one lipid profiles (or ALL component tests) during the 12 month review period **(Adults and Chidren≥16 years old)**
3. Annual Urine Protein Screening (or microalbumin) during the 12 month review period **(Adults and Chidren≥16 years old)**
4. Annual Eye Exam – percentage of patients who received a dilated eye exam by an ophthalmologist or optometrist during the 12 month review period **(Adults and Chidren≥16 years old)**
5. Annual Influenza Vaccination – percentage of patients who received an influenza vaccination during 12 month review period **(Children and Adults)**

Asthma QI Measures (Adult and Pediatric)

1. **Asthma Controller Use** – 1a) Percentage of patients with an ED visit and/or hospital admission who subsequently fill <1 prescription every three months for an inhaled steroid, either alone or in combination, 1b) Percentage of patients who fill >2 short acting bronchodilator prescriptions every year who subsequently fill <1 prescription every three months for an inhaled steroid, either alone or in combination, or fill < 2 prescriptions every three months for leukotriene modifiers or mast cell stabilizers.
2. **Annual Influenza Immunization** – Percentage of patients with an asthma diagnosis who receive an influenza immunization during each calendar year
3. **Emergency Department Visits** – Percentage of patients with an asthma diagnosis who have ≥1 ED visit during a calendar year
4. **Hospitalization** – Percentage of patients with an asthma diagnosis who have ≥1 inpatient admission for asthma treatment during a calendar year.

APPENDIX G: PRICING SHEETS

Pricing Schedule 1: Firm and Fixed Costs

Fixed costs effective through September 30, 2009	
Company:	Date:
Authorized Signature:	

	Deliverable/Event	Fixed Cost	Percent of Total Implementation Cost	May Not Exceed
C	Submission of Final Project Plan			5%
D	ALAHIS Operating Environment Development			10%
E	HHS Interoperability Resolution			5%
F	Data Integration Solutions			15%
G	Development of Clinical Tool (ECST)			10%
H	Initial Version of HIS, including ECST			5%
I	Unit and Integration Testing			15%
J	Submission of Training Materials			5%
K	End User Training			5%
L	Implementation of Pilot Test			15%
M	Interface with HHS Agency			10%
	Total Cost for Implementation			

N	Ongoing Support/Maintenance 3/08-9/30/09	
	Total Firm and Fixed Price	

NOTE: Alpha characters refer to specific deliverables described in Section IX.

Pricing Schedule 2: Hardware and Software

Manufacturer's Name, Model, Version, etc.	Proprietary (Y/N)	Purpose
Hardware (List the cost of all hardware components separately):		
Software (Include DBMS, Development Tools, Licenses, etc. Also List the cost of software license(s) per # of user's/license, and designate if it is a site or seat license.):		

Pricing Schedule 3: Project Fixed Hourly Rates

Fixed Hourly Rates effective through September 30, 2009	
Company:	Date:
Authorized Signature:	

Job Title	**Fixed Hourly Rate**
Project Manager	$
Business Analyst	$
Technical Architect	$
Database Architect	$
Developer (Java)	$
Developer (.Net)	$
QA Tester	$
Application Maintenance Technician	$
Conversion Manager	$
Conversion Business Analyst	$
Conversion Programmer	$
Help Desk Technician	$
Other:	$
Other:	$

APPENDIX H: CONTRACT AND ATTACHMENTS

The following are the documents that must be signed and returned with the Vendor's proposal. Sections to be completed by Vendor are highlighted in yellow.

Contract

Attachment A: Business Associate Agreement
Attachment B: Contract Review Report for Submission to Oversight Committee
Attachment C: Immigration Status
Attachment D: Disclosure Statement
Attachment E: Letter Regarding Reporting to Ethics Commission
Attachment F: Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Contractor agree as follows:

Contractor shall furnish all labor, equipment, and materials and perform all of the work required under the Request for Proposal (RFP) Number 2007-TFQ-01, dated June 29, 2007, strictly in accordance with the requirements thereof and Contractor's response thereto.

Contractor shall be compensated for performance under this contract in accordance with the provisions of Section _XV_ and the Pricing Schedule provided for within the RFP.

This contract specifically incorporates by reference the RFP, any amendments thereto, and Contractor's response, including all attachments.

EXECUTED THIS _____ DAY OF _____, 2007.

CONTRACTOR

_____

_____
Printed Name

ALABAMA MEDICAID AGENCY
This contract has been reviewed
for and is approved as to content.

_____
Commissioner

This contract has been reviewed for legal form and complies with all Applicable laws, rules and regulations of the State of Alabama governing these matters.

_____
Medicaid Legal Counsel

APPROVED

_____
Governor, State of Alabama

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule (as defined below).

c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

b. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

c. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

d. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

e. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

f. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

g. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.

b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.

c. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

e. Applicability to Business Associate's Agents. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.

f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524, access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.

g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.

h. Availability of Documents. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule, within five business days' after receipt of written notice.

i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity;

a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:

1) disclosures are Required By Law; or

2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

b. Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

6. TERM AND TERMINATION

a. **Term**. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2) Immediately terminate this Agreement; or

3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

1) Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

e. The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY	**BUSINESS ASSOCIATE**
Signature: _____	Signature: _____
Printed Name: Paul Brannan	Printed Name: _____
Title: Privacy Officer	Title: _____
Date: _____	Date: _____

Attachment B

Contract Review Permanent Legislative Oversight Committee
Alabama State House
Montgomery, Alabama 36130

C O N T R A C T R E V I E W R E P O R T
(Separate review report required for each contract)

Name of State Agency: Alabama Medicaid Agency

Name of Contractor: _____

_____ _____ _____

Contractor's Physical Street Address(No. P.O. Box) City State/Zip
Is Contractor Registered with Alabama Secretary of State to do Business as a Corporation in Alabama?
YES _____NO ____If Yes, in what State is Contractor Incorporated? _____
Is Act 2001-955 Disclosure Form Included with this Contract? YES NO _____
Was a Lobbyist/Consultant Used to Secure this Contract? YES NO _____
If Yes, Give Name: _____
Contract Number: _____
Contract/Amendment Total: _____
% of State Funds: _____ % of Federal Funds: _____ % Other Funds: **
**Please Specify source of Other Funds (Fees, Grants, etc.) _____
Date Contract Effective: _____ Date Contract Ends: _____
Type of Contract: NEW: _____ RENEWAL: _____ AMENDMENT: _____
If renewal, was it originally Bid? Yes _____ No _____

If AMENDMENT, Complete A through C:

[A] Original contract total $ _____
[B] Amended total prior to this amendment $ _____
[C] Amended total after this amendment $ _____

Was Contract secured through Bid Process? Yes ___ No ___ Was lowest Bid accepted? Yes ___ No____
Was Contract secured through RFP Process? Yes ____ No ____
Summary of Contract Services to be Provided:

_____

_____

Why Contract Necessary AND why this service cannot be performed by merit employee:

_____

_____

I certify that the above information is correct.

_____ _____

Signature of Agency Head Signature of Contractor

Carol H. Steckel, Commissioner _____

Printed Name Printed Name

Agency Contact: Mary Ann Fannin Phone: 242-5833

If this contract was not competitively Bid, why?

_____

_____

If this contract was not competitively Bid because the contractor is a sole source provider, please explain who made the sole source determination and on what basis:

_____

_____

_____

If contract was awarded by RFP, what process was used, how many vendors were contacted, and how many proposals were received:

_____

_____

_____

If this contract was not awarded through either Bid or RFP process, why? _____

_____

Did agency attempt to hire a State Employee? If so who from Personnel Department did you talk to?

_____

_____

_____

How many additional contracts does contractor have with the State of Alabama and which agencies are they with?

_____

_____

_____

_____

Carol H. Steckel, Commissioner

Attachment C

IMMIGRATION STATUS

I hereby attest that all workers on this project are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

_____

Signature of Contractor

_____

Witness

Attachment D

State of Alabama
Disclosure Statement

(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER ( )

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

Alabama Medicaid Agency

ADDRESS

501 Dexter Avenue, PO Box 5624

CITY, STATE, ZIP

Montgomery, Alabama 36103-5624

TELEPHONE NUMBER

(334)242-5833

This form is provided with:

☐ Contract ☐ Proposal ☒ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

Attachment E

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov
Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

BOB RILEY
Governor

CAROL H. STECKEL, MPH
Commissioner

January 1, 2007

MEMORANDUM

TO: All Persons Under Contract With the Agency and All Agency Staff

FROM: Carol H. Steckel, MPH
Commissioner

SUBJECT: Reporting to Ethics Commission by Persons Related to Agency Employees

Section 36-25-16(b) Code of Alabama (1975) provides that anyone who enters into a contract with a state agency for the sale of goods or services exceeding $7500 shall report to the State Ethics Commission the names of any adult child, parent, spouse, brother or sister employed by the agency.

Please review your situation for applicability of this statute. The address of the Alabama Ethics Commission is:

100 North Union Street
RSA Union Bldg.
Montgomery, Alabama 36104

A copy of the statute is reproduced below for your information. If you have any questions, please feel free to contact Bill Butler, Agency General Counsel, at 242-5741.

Section 36-25-16. Reports by persons who are related to public officials or public employees and who represent persons before regulatory body or contract with state.

(a) When any citizen of the state or business with which he or she is associated represents for a fee any person before a regulatory body of the executive branch, he or she shall report to the commission the name of any adult child, parent, spouse, brother, or sister who is a public official or a public employee of that regulatory body of the executive branch.
(b) When any citizen of the State or business with which the person is associated enters into a contract for the sale of goods or services to the State of Alabama or any of its agencies or any county or municipality and any of their respective agencies in amounts exceeding seven thousand five hundred dollars ($7500) he or she shall report to the commission the names of any adult child, parent, spouse, brother, or sister who is a public official or public employee of the agency or department with whom the contract is made.
(c) This section shall not apply to any contract for the sale of goods or services awarded through a process of public notice and competitive bidding.
(d) Each regulatory body of the executive branch, or any agency of the State of Alabama shall be responsible for notifying citizens affected by this chapter of the requirements of this section. (Acts 1973, No. 1056, p. 1699, §15; Acts 1975, No. 130, §1; Acts 1995, No. 95-194, p. 269, §1.)

Instructions for Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

(Derived from Appendix B to 45 CFR Part 76--Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions)

1. By signing and submitting this contract, the prospective lower tier participant is providing the certification set out therein.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Alabama Medicaid Agency (the Agency) may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the Agency if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, and voluntarily excluded, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this contract is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this contract that, should the contract be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this contract that it will include this certification clause without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that

which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the Agency may pursue available remedies, including suspension and/or debarment.